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No.

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1986

MONSOUR MEDICAL CENTER,

Petitioner,

v.

OTIS R. BOWEN, M.D., Secretary
of the United States
Department of Health and
Human Services, and
WILLIAM L. ROPER, M.D., Administrator,
Health Care Financing Administration,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTIONS PRESENTED

1. Whether this Court should consider preclusion of nonparties — an issue largely unaddressed by this Court's recent decisions — when Petitioner hospital's state court judgment against its Medicare intermediary has not been given preclusive effect against Medicare in a later action even though both lawsuits involved the same factual record and the same legal question.

2. Whether this Court should resolve a conflict among the Circuits over the proper interpretation of Medicare's related-parties regulation, when the Third Circuit's interpretation excludes from consideration highly probative evidence, wrongly defers to inconsistent administrative interpretations, and will erect an unjustified bar to the sale or transfer of health-care facilities.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	2
JURISDICTION	2
STATUTES AND REGULATION INVOLVED	2
STATEMENT	2
1. The Reimbursement Background	3
2. The Conversion Proposal	5
3. The State Court Action	6
4. Medicare Disallows The Conversion-Related Expenses	7
5. The District Court Reverses	8
6. The Court of Appeals Reverses	9
REASONS FOR GRANTING THE WRIT	10
I. COLLATERAL ESTOPPEL BARS RELITIGATION IN THIS CASE EVEN THOUGH THE SECRETARY WAS NOT A FORMAL PARTY TO THE STATE COURT JUDGMENT	11
A. The Third Circuit's Collateral Estoppel Ruling Conflicts With Decisions Of Other Courts	12
B. Sound Judicial Policy Requires Collateral Estoppel Of Nonparties Whose Interests Are Identical To The Interests Of Parties To The Previous Action When The First Proceeding Fully And Fairly Addressed The Issue	15
C. No Special Interest Of The Federal Government Bars Collateral Estoppel In This Case	16

TABLE OF CONTENTS—*(Continued)*

	Page
II. THE THIRD CIRCUIT'S DECISION ERRONEOUSLY EXPANDS THE RELATED PARTIES REGULATION AND DEFERS TO AN INCONSISTENT ADMINISTRATIVE INTERPRETATION...	18
CONCLUSION	22

TABLE OF AUTHORITIES

Cases: Page

American Hosp. Mgt. Corp. v. Harris, 638 F.2d 1208 (9th Cir. 1981) 19

Anderson v. City of Bessemer City, N.C., 105 S.Ct. 1504 (1985) 20

Artrip v. Califano, 569 F.2d 1298 (4th Cir. 1978) 15

Becher v. Contoure Laboratories, Inc., 279 U.S. 388 (1929) 18

Bellwood General Hosp. v. Schweiker, 673 F.2d 1043 (9th Cir. 1982) 19, 20

Blonder-Tongue Laboratories, Inc. v. University of Illinois Foundation, 402 U.S. 313 (1971) 11

Blue Cross of Western Pennsylvania v. Monsour Medical Center, 491 A.2d 914 (1985) 2, 7

Cauefield v. Fidelity and Casualty Co. of New York, 378 F.2d 876 (5th Cir.), *cert. denied*, 389 U.S. 1009 (1967) 13

Chelsea Community Hosp., SNF v. United States, 2 Cl. Ct. 175 (1983) 19

Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402 (1971) 22

Friedenthal v. General Insurance Co. of America, 395 F.2d 202 (5th Cir. 1968) 14

General Foods v. Mass. Dept. of Public Health, 648 F.2d 784 (1st Cir. 1981) 14

Hospital Dr. Tito Mattei, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶34,967 (HCFA Administrator Decision Aug. 27, 1985) 21

Hospital Dr. Tito Mattei, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶34,869 (P.R.R.B. July 1, 1985) 20

TABLE OF AUTHORITIES—*(Continued)*

Cases:	Page
Jackson Park Hosp. Foundation v. United States, 659 F.2d 132 (Ct. Cl. 1981)	19
Kremer v. Chemical Constr. Corp., 456 U.S. 461 (1982)	16
Marrese v. American Academy of Orthopaedic Surgeons, 105 S.Ct. 1327 (1985)	12
Memorial, Inc. v. Harris, 655 F.2d 905 (9th Cir. 1980)	17
Midway Youth Football Ladies Aux. v. Strickland, 449 F. Supp. 418 (N.D. Ga. 1978)	14
Montana v. United States, 440 U.S. 147 (1979)	*passim*
North Haven Board of Education v. Bell, 456 U.S. 512 (1982)	21
Pacific Coast Medical Enterprises v. Harris, 633 F.2d 123 (9th Cir. 1980)	18-19
Parklane Hosiery Co. v. Shore, 439 U.S. 322 (1979)	11
Procter & Gamble Co. v. Byers Transp. Co., 355 F. Supp. 547 (W.D. Mo. 1973)	13
Ramos v. Horton, 456 S.W.2d 565 (Tex. Civ. App. 1970)	14
Shaker Med. Center Hosp. v. Secretary, 686 F.2d 1203 (6th Cir. 1982)	19
Southeastern Community College v. Davis, 442 U.S. 397 (1979)	21
Southern Pacific R.R. v. United States, 168 U.S. 1 (1897)	15
Southwest Airlines Co. v. Texas Intern. Airlines, 546 F.2d 84 (5th Cir.), *cert. denied*, 434 U.S. 882 (1977)	14
Trustees of Indiana University v. United States, 618 F.2d 736 (Ct. Cl. 1980)	19

TABLE OF AUTHORITIES—*(Continued)*

Cases: Page

United Housing Foundation, Inc. v. Forman, 421 U.S. 837 (1975) 21

United States v. ITT Rayonier, Inc., 627 F.2d 996 (9th Cir. 1980) 13, 16

United States v. Mendoza, 464 U.S. 154 (1984) 16-17

United States v. Moser, 266 U.S. 236 (1924) 15

United States v. Stauffer Chemical Co., 464 U.S. 165 (1984) 17

United States v. Utah Constr. & Mining Co., 384 U.S. 394 (1966) 11

Universal Camera Corp. v. NLRB, 340 U.S. 474 (1951) .. 22

University of Tennessee v. Elliot, 106 S.Ct. 3220 (1986) 12, 16

Urdiales v. St. Paul Mercury Ins. Co., 445 F.2d 296 (9th Cir. 1971) 14

Wilson v. Attaway, 757 F.2d 1227 (11th Cir. 1985) 15

Statutes and Regulations:

5 U.S.C. § 706(2)(E) 22

28 U.S.C. § 1254(1) 2

28 U.S.C. § 1738 12

42 U.S.C. §§ 1395f(b), 1395x(v)(1)(A) 3

42 U.S.C. § 1395(h) 2, 4

42 U.S.C. § 1395*oo*(f)(1) 2, 22

42 C.F.R. § 405.1843 (1986) 7

42 C.F.R. § 413.157 (1986) 5

42 C.F.R. § 413.17 (1986) 2, 5, 9

42 C.F.R. § 421.100 (1986) 4

TABLE OF AUTHORITIES—*(Continued)*

Miscellaneous: Page

Health Care Financing Administration, "Intermediary Workload Report," March 1986 4

Berch, "A Proposal to Permit Collateral Estoppel of Nonparties Seeking Affirmative Relief," 1979 *Ariz. St. L.J.* 511 14

Comment, "Nonparties and Preclusion by Judgment: The Privity Rule Reconsidered," 56 *Calif. L. Rev.* 1098 (1968) 14

Comment, "Mandatory Intervention: Expansion of Collateral Estoppel in Favor of Single Defendants Against Multiple Plaintiffs in Federal Civil Litigation," 14 *John Marshall L. Rev.* 441 (1981) 14

George, "Sweet Uses of Adversity: *Parklane Hosiery* and the Collateral Class Action," 32 *Stan. L. Rev.* 655 (1980) 14

Note, "Preclusion of Absent Disputants to Compel Intervention," 79 *Colum. L. Rev.* 1551 (1979) 14

Note, "Collateral Estoppel of Nonparties," 87 *Harv. L. Rev.* 1485 (1974) 14

Vestal, "Preclusion/Res Judicata Variables: Parties," 50 *Iowa L. Rev.* 27 (1964) 11

Vestal, "The Restatement (Second) of Judgments: A Modest Dissent," 66 *Cornell L. Rev.* 464 (1981) 14

Vestal, "Res Judicata/Preclusion: Expansion," 47 *S. Cal. L. Rev.* 357 (1974) 14

Secretary's Br., *Medical Center of Tarzana v. Heckler*, No. 83-6077 (9th Cir. Dec. 16, 1985) 21

Provider Reimbursement Manual §1004.3 20

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Monsour Medical Center hereby petitions for issuance of a writ of certiorari to review the decision and judgment of the Court of Appeals for the Third Circuit in *Monsour Medical Center v. Heckler, et al.*, Nos. 86-3191 & 86-3168, issued on December 5, 1986.

1. The initial complaint named as defendants, in their official capacities, Margaret Heckler, then Secretary of Health and Human Services, and Carolyne Davis, then Administrator, Health Care Financing Administration (HCFA). Because both named parties have been succeeded in office, the current defendants are properly Dr. Bowen and Dr. Roper, pursuant to Rule 43(c) of the Federal Rules of Appellate Procedure.

Under Pennsylvania law of non-profit entities, the Monsour Medical Foundation is the sole member of the Monsour Medical Center.

OPINIONS BELOW

The decision of the court of appeals (Pet. App. A, pp. A-1 to A-21, *infra*) is reported at 806 F.2d 1185 (3d Cir. 1986). The decision of the district court of December 30, 1985 (Pet. App. B, pp. A-22 to A-35, *infra*) is reported at [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,083. The decision of the Provider Reimbursement Review Board of June 14, 1984 (Pet. App. C, pp. A-36 to A-66, *infra*) is reported at [1984-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,138. The order of the Pennsylvania Superior Court in a related proceeding, *Blue Cross of Western Pennsylvania v. Monsour Medical Center*, is reported at 491 A.2d 914 (1985) (Pet. App. D, pp. A-67 to A-68, *infra*). The verdict of the Allegheny County Court of Common Pleas in that related case (Pet. App. E, pp. A-69 to A-85, *infra*) and that court's decision on post-trial motions (Pet. App. F, pp. A-86 to A-93, *infra*) are unreported.

JURISDICTION

The decision of the court of appeals was issued on December 5, 1986. A timely motion for rehearing and suggestion for rehearing *en banc* was denied on January 6, 1987 (Pet. App. G, pp. A-94 to A-95, *infra*). The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

STATUTES AND REGULATION INVOLVED

Sections 1395(h) and 1395*oo*(f)(1) of Title 42, United States Code, and 42 C.F.R. § 413.17 are reproduced in Pet. App. H, pp. A-96 to A-105, *infra*.

STATEMENT

In 1952, the four Monsour brothers, all of whom are doctors, established the Monsour Hospital & Clinic, Inc., a proprietary hospital in Jeannette, Pennsylvania. R. 18-19;[2] Pet. App.

2. Citations to the administrative record will be indicated either by "R. ," or, for references to the transcript of the state court trial (which is also part of the administrative record), by "Trial Tr. _____(Vol. _____)."

C, at A-49. In succeeding years, the hospital developed into an acute-care facility with 233 beds "offering medical services of a highly complex nature and variety." Pet. App. E, at A-72.

The Monsours dreamed of a medical complex — like the Mayo Clinic or the Geisinger Clinic — dedicated to caring for the sick, to medical research, and to medical education. Trial Tr. 398-99 (Vol. VII). In pursuit of that goal, in 1966 they established the non-profit Monsour Medical Foundation. *Id.* The Foundation sponsored "civic and educational programs in the medical field, provided scholarships for both medical and nursing students," and supported basic medical research. Pet. App. E, at A-72.

The Monsours hoped to convert the hospital to a non-profit facility that would be part of the Foundation. Such a conversion would enhance the hospital's ability to participate in grant and research programs, facilitate fund-raising, and provide other financial benefits. Pet. App. E, at A-72; Trial Tr. 944-47 (Vol. VIII). In 1975, that conversion was accomplished. This Petition concerns the hospital's right to Medicare reimbursement of the interest and depreciation costs related to the hospital's 1975 conversion to non-profit status.[3]

1. The Reimbursement Background

The critical consideration for the Monsour conversion was reimbursement of the conversion-related expenses by its major third party payors, the federal Medicare program and Blue Cross of Western Pennsylvania ("Blue Cross"). Under the Medicare Act, the hospital's reimbursement was based on the "reasonable cost" incurred in providing services to Medicare patients. 42 U.S.C. §§ 1395f(b), 1395x(v)(1)(A). For example, if a hospital furnished 30 per cent of its services to Medicare patients, Medicare

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3. Petitioner does not seek review of a second issue raised in the proceedings below concerning the hospital's food-service expenses.

would reimburse approximately 30 per cent of the hospital's allowable costs, including capital costs.[4]

For the relevant period, Blue Cross was the hospital's "fiscal intermediary" under the Medicare program, with responsibility for determining the reasonable costs to be reimbursed by Medicare. 42 U.S.C. § 1395(h). Among the intermediary's responsibilities are overseeing payment of Medicare benefits, auditing health care providers, and providing procedures for review and reconsideration of coverage decisions. 42 C.F.R. § 421.100 (1986).

At the same time, Blue Cross operated its own private insurance program, largely by applying Medicare's cost-reimbursement regulations under private contracts with hospitals. Trial Tr. 133, 140, 145-46 (Vol. VI). This combination of private and public functions is customary for Medicare intermediaries. In 1985, virtually all of the roughly 50 Medicare intermediaries were insurance companies that also sell private health insurance. *See* Health Care Financing Administration, "Intermediary Workload Report," March 1986 (listing intermediaries).

Blue Cross jointly administered its Medicare business and its private insurance business. Audits for both programs were coordinated, with the auditors discussing common issues, Trial Tr. at 2169-70 (Vol. X), sharing work papers, *id.*, at 323-24 (Vol. VI), comparing discrepancies to reconcile their approaches, *id.*, at 324-25, and reporting to a single Blue Cross audit manager, Jackson Lynch. *Id.*, at 594-95 (Vol. VII). Indeed, in the 1970s if Blue Cross's private insurance auditors went to the hospital first, Blue Cross's Medicare auditors simply adopted the private auditors' reports. *Id.*, at 323-24 (Vol. VI). Since 1980, the private and Medicare audits have been consolidated formally into a single audit by Blue Cross. *Id.*, at 119.

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4. In 1983 legislation, Congress approved for Medicare a prospective payment system, which provides a flat payment per patient and retains "cost-reimbursement" only for capital costs. The issues in this Petition, however, involve only capital costs under the cost-reimbursement system.

2. The Conversion Proposal

The hospital retained special counsel to plan the hospital's conversion to non-profit status as a part of the Foundation. Pet. App. B, at A-23. After securing approval for a conversion plan from the Pennsylvania Attorney General and the Internal Revenue Service, the hospital needed approval by Blue Cross acting both as Medicare intermediary and as a private insurer. Pet. App. E, at A-72 to A-74.

So long as the hospital was proprietary, it was entitled to Medicare reimbursement of a "rate of return" on its capital assets. 42 C.F.R. § 413.157 (1986). That reimbursement would cease after conversion to non-profit status, even though the hospital would incur capital costs in purchasing the hospital's assets from the individual Monsours. Unless those new and different capital costs — interest and increased depreciation due to revaluation of the assets — were reimbursed by both Medicare and Blue Cross, the conversion would not be economically feasible. Trial Tr. 935 (Vol. VII), 1864-68, 1987-89 (Vol. IX).

As first proposed in early 1975, the conversion was rejected by Blue Cross under Medicare's "related parties" regulation, now codified at 42 C.F.R. § 413.17 (1986) (formerly at 42 C.F.R. § 405.427), which is designed to prevent self-dealing. Notably, the same Blue Cross official, Edward Marinac, reviewed the Monsour conversion for Blue Cross in its private capacity and as Medicare intermediary. Trial Tr. 605 (Vol. VII). Hospital counsel then revised the proposed transaction, Pet. App. E, at A-73 to A-74; Trial Tr. 2096-2104 (Vol. X), and Marinac, as the district court found, "approved the structure before the conversion." Pet. App. B, at A-24.

The Foundation and hospital boards completed the conversion on May 17, 1975. The Monsours abstained from the Foundation action, which was taken by the other nine Foundation directors, and no Monsour served on the hospital board. Pet. App. A, at A-3 to A-4, A-14. The Monsours sold to the Foundation 3.5 per cent of the hospital stock for $500,000. They exchanged 49.8 per cent of the stock with the new hospital for a

twenty-year note for $7.5 million, secured by a second mortgage, with interest at six per cent for the first five years and at the prime rate thereafter. Pet. App. A, at A-2 to A-3. The balance of the Monsours' hospital stock was donated to the Foundation.

In a letter dated July 17, 1975, Jackson Lynch wrote that "as Medicare intermediary" Blue Cross accepted the conversion "as between distinct and unrelated entities . . . resulting in a bona fide sale." R. 1450. Lynch added that the approval was "conditional until a special audit" of the first year of operations was completed. *Id.* Marinac conducted the special audit, which was terminated in the spring of 1977. R. 1544. Both Blue Cross and Medicare reimbursed their respective shares of the conversion-related expenses until April of 1981.

3. The State Court Action

In February 1980, financial difficulties forced the hospital into a Chapter 11 reorganization. After a year of litigation with the hospital over other matters, Blue Cross announced in April 1981 that the 1975 conversion had not been between related parties. Blue Cross refused to reimburse the conversion-related expenses, and recouped its previous reimbursement of those expenses. Pet. App. A, at A-4.

Blue Cross also sued the hospital and the Monsours in the Allegheny County Court of Common Pleas, alleging fraud and unjust enrichment and seeking a declaration that the 1975 conversion did not satisfy Medicare's "related parties" regulations. The defendants counterclaimed, asking for a declaration that the conversion satisfied the Medicare rules.

After extensive discovery, the case was tried to the bench for three weeks in January of 1983. The state court heard testimony by 22 live witnesses, received deposition testimony of another 8 witnesses, and reviewed 140 documentary exhibits. R. 745-46. Witnesses included three of the Monsour brothers, five current and former hospital officials, the hospital's outside auditor at the time of the conversion, several former hospital attorneys, and six hospital or Foundation board members.

The state court held that the 1975 conversion satisfied the Medicare regulations, noting numerous incidents reflecting the Monsours' lack of control over the hospital and the Foundation (Pet. App. B, at A-30; Pet. App. E, at A-77, A-79, A-82):

— "The hospital's bankruptcy petition in 1980 was filed over the objections of William Monsour";

— "An executive vice president [administrator] of the hospital was retained even though Howard Monsour urged the board that he be dismissed for incompetence";

— "William Monsour was forced by the Board of the Foundation to resign as chairman";

— The hospital skipped payments to the Monsours on the second mortgage, which "eventually went into serious arrearage."

The state court concluded that "it was never intended that control of the hospital continue in the Monsours subsequent to the conversion nor has such control continued in fact." Pet. App. E, at A-82. After a full appeal, the Pennsylvania Superior Court affirmed. 491 A.2d 914 (1985).

4. Medicare Disallows The Conversion-Related Expenses

Blue Cross in 1981 prodded Medicare to disallow the conversion expenses retroactively. Trial Tr. 2346-47, 2369-72, 2378 (Vol. X). In December 1981, Medicare directed Blue Cross to cut off further Medicare reimbursement of the conversion-related expenses and to recoup five years' worth of such reimbursement. R. 2968-69, 2913-14.

The hospital challenged Medicare's action at a hearing before Medicare's Provider Reimbursement Review Board (PRRB) in October 1983, in which the hospital was opposed by the intermediary, Blue Cross. 42 C.F.R. § 405.1843 (1986) (intermediary represents Secretary before PRRB). Blue Cross presented no witnesses on the conversion issue, relying solely upon the

state court trial transcript, certain trial exhibits, and certain limited discovery materials from that case. The hospital asked the PRRB to give effect to the state court ruling. R. 776-90, 2709-10.

The PRRB ignored the state court ruling and approved the disallowance of the conversion-related expenses. The Board stressed a single point: that the conversion as consummated closely resembled the planned conversion. From this fact, the PRRB concluded that the Foundation trustees who approved the conversion "were acting as surrogates" of the Monsours. The Board's reasoning — later described by the Third Circuit as "syllogistic" (Pet. App. A, at A-13) — was as follows (Pet. App. C, at A-63):

> There is no question that the Family, the Foundation, and the [hospital] were related when the entire transaction was specifically planned. The fact that the transaction was executed almost precisely as planned demonstrates the continuation of substantial control in fact.

The Secretary of Health and Human Services declined to "reverse, affirm, or modify the PRRB ruling." R. 002.[5]

5. The District Court Reverses

On appeal to the United States District Court for the Western District of Pennsylvania, the hospital argued that the PRRB ruling was barred by collateral estoppel and was not supported by substantial evidence. The district court noted that "in the interests of federal-state comity, uniformity of interpretation, and *stare decisis*, we are tempted to apply the state court findings without further review." Pet. App. B, at A-26. But the district court held that Blue Cross and Medicare were not in privity for collateral estoppel purposes, and that Medicare had not had

5. The PRRB held, as an alternative ground, that the conversion was a stock transaction, not an asset transaction, and therefore could not create reimbursable expenses. This holding was rejected by the district court because Blue Cross stipulated at the PRRB hearing that the conversion was an asset transaction. Pet. App. B, at A-31. This issue, therefore, does not arise in this Petition.

a "full and fair" opportunity to litigate the issues in the state court action.

Applying the "substantial evidence" standard for review of the agency decision, the district court reversed the PRRB's decision as based on "suspicion or reaction," not fact. The district court found that the PRRB's presumption that the Foundation trustees acted as "surrogates" of the Monsours was contradicted by extensive record evidence. *Id.*, at A-28 to A-30.

6. The Court of Appeals Reverses

The United States Court of Appeals for the Third Circuit reversed. The appellate panel agreed that the state court decision should not preclude the Secretary from relitigating the conversion issue. Citing a single decision, *Montana v. United States*, 440 U.S. 147 (1979), the court of appeals emphasized that there was no evidence that the Secretary had controlled Blue Cross in the state court proceeding. Without such control during the Blue Cross litigation, the court concluded, "the state court findings . . . should not be given legally preclusive effect in this federal action." Pet. App. A, at A-17.

The court of appeals found substantial evidence for the PRRB's conclusion that the conversion was a related parties transaction. The Medicare regulation provides that related parties are present "where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution." 42 C.F.R. § 413.17 (1986).

The court of appeals dismissed as a "syllogism" the PRRB's reasoning on this issue, but then repeated that syllogism: "The record thus indicates that the conversion went exactly as the Monsour family members . . . had planned. Complicated organizational and financial structures simply cannot conceal or negate such substantial record evidence of the Monsours' direct power significantly to influence the actions or policies of the Foundation at the time of the conversion." Pet. App. A, at A-14.

Claiming to defer to the Secretary's interpretation of the related parties regulation, the court of appeals refused even to

consider record evidence that the Monsours did not control the Foundation or the hospital after the conversion. "Such evidence," the court wrote, "while interesting, is not material to the legal issue before us." *Id.*, at A-15 n. 25.

REASONS FOR GRANTING THE WRIT

The state court judgment applied the same legal standard to the same factual record involved in this case. Yet the ruling in this case is exactly the opposite of the state court judgment. The collateral estoppel doctrine exists to prevent just such contradictory outcomes. Indeed, all of the policies that animate collateral estoppel are implicated here: preventing vexatious relitigation, enforcing repose, preventing inconsistent rulings and providing for due respect and comity between the federal and state court systems.

That the Secretary and Blue Cross are nominally different parties does not alter this analysis. This Court held in *Montana v. United States*, *supra*, that the federal government may be estopped on the basis of a prior judgment to which it was not a party, and the fact-sensitive approach taken in *Montana* is directly contrary to the Third Circuit's mechanical refusal to apply collateral estoppel. Other courts have held that nonparties, including the federal government, can be estopped by prior judgments when (i) there is an identity of interests between the party to be estopped and the party in the previous action; and (ii) there is no unfairness from applying estoppel in the second action. The law on this issue is unsettled, with both state and federal courts announcing different policies towards collateral estoppel of nonparties.

The Third Circuit's decision limiting collateral estoppel will encourage the federal government and other parties to relitigate cases in pursuit of more favorable judgments. The decision also violates basic notions of federalism, betraying a disturbing disregard for state court judgments. The significance of this issue warrants plenary review by this Court.

In addition, the Third Circuit adopted a unique and unreasonably restrictive interpretation of Medicare's related parties

regulation. Unlike other courts, the Third Circuit refused to consider the totality of the circumstances of the transaction at issue, indulging instead a presumption based upon "syllogistic" reasoning. Because of the inconsistency between the Third Circuit's approach and the decisions of other courts, and because the Third Circuit's decision will prevent unobjectionable hospital transactions, the issue should be reviewed by this Court.

I.
COLLATERAL ESTOPPEL BARS RELITIGATION IN THIS CASE EVEN THOUGH THE SECRETARY WAS NOT A FORMAL PARTY TO THE STATE COURT JUDGMENT

Collateral estoppel increasingly has been enforced to prevent the waste caused by relitigation of disputes, including relitigation before administrative bodies like the PRRB. *See United States v. Utah Constr. & Mining Co.*, 384 U.S. 394, 421-23 (1966). In *Blonder-Tongue Laboratories, Inc. v. University of Illinois Foundation*, 402 U.S. 313 (1971), this Court abandoned the "mutuality" requirement which had stated that a judgment could not be the basis for an estoppel unless both parties to the second lawsuit were bound by the prior judgment. "Offensive" collateral estoppel later was approved conditionally in *Parklane Hosiery Co. v. Shore*, 439 U.S. 322 (1979), allowing a plaintiff to enforce against a defendant a judgment to which the plaintiff had not been party.

A central remaining issue is the extent to which a judgment may be used to estop a party who did not participate in the first proceeding. Traditionally, collateral estoppel has been extended to nonparties who were described as "privies" to the prior lawsuit, and the lower courts often use that language. But this Court has observed that privity provides a description rather than an analysis of nonparty estoppel. *Montana v. United States*, *supra*, 440 U.S. at 154 n.5; *see* Vestal, "Preclusion/Res Judicata Variables: Parties," 50 *Iowa L. Rev.* 27 (1964). Accordingly, the *Montana* Court did not rely on privity as a basis for collateral estoppel

against the United States, but applied a flexible analysis emphasizing that the government had been deeply involved in directing the litigation which produced the prior state court judgment. The Court wrote, "although not a party, the United States plainly had a sufficient 'laboring oar' in the conduct of the state-court litigation to actuate principles of estoppel." 440 U.S. at 155.

With only *Montana* as guidance from this Court, the courts are divided on the estoppel of nonparties. After canvassing decisions contrary to the Third Circuit's holding, this Petition will explore the critical judicial policies that support application of collateral estoppel here, and will explain why the federal government is not entitled to any special exception from collateral estoppel in this case.[6]

A. The Third Circuit's Collateral Estoppel Ruling Conflicts With Decisions Of Other Courts

The Third Circuit, after noting that the Secretary was not a party to the state court proceeding, held that "to estop the federal government" the hospital "would have to prove that 'the United States exercised control over Blue Cross's Pennsylvania court suit.'" Pet. App. A, at A-16 (quoting *Montana*). Because the precise facts in *Montana* are not present here, the Third

6. In refusing to give preclusive effect to the Pennsylvania judgment, the district court and the Third Circuit apparently applied a federal common law of preclusion, as neither court examined the preclusive effect that the Pennsylvania judgment would have as a matter of state law. Indeed, this Court frequently has crafted federal common law in this area, and 28 U.S.C. § 1738, which generally governs the preclusive effect given to state court judgments, does not address the effect of such judgments on adjudication by federal agencies like the PRRB. *See University of Tennessee v. Elliot*, 106 S. Ct. 3220, 3224 (1986) ("we have frequently fashioned federal common law rules of preclusion in the absence of a governing statute"). If the lower courts erred in applying federal common law instead of Pennsylvania rules of preclusion, the proper remedy would be to remand this case with directions that the district court must consider Pennsylvania rules of preclusion. *Marrese v. American Academy of Orthopaedic Surgeons*, 105 S. Ct. 1327 (1985). Petitioners have consistently argued that Pennsylvania law would afford preclusive effect to the state court judgment in the PRRB proceedings. *See* Appellants' Reply Brief, at 28.

Circuit refused to apply collateral estoppel. *Id.* That holding conflicts with decisions of several courts which, following a full analysis of the relevant facts and interests of the various parties, have precluded relitigation by nonparties whom they sometimes describe as privies to the first action.

United States v. ITT Rayonier, Inc., 627 F.2d 996 (9th Cir. 1980), concerned enforcement of water pollution discharge limits by the federal Environmental Protection Agency (EPA) and the Washington State Department of Ecology. After EPA gave authority to the state to issue discharge permits, the state established a compliance schedule for Rayonier. That schedule was upheld by the Washington Supreme Court. EPA nevertheless brought a federal enforcement action against Rayonier, which argued that the state ruling should be given collateral estoppel effect against the federal EPA.

In a passage of particular relevance, the Ninth Circuit wrote, "The real question in the context of this suit is the conflict between state and federal courts . . .. We do not perceive how the need for uniformity under the [federal statute] is best promoted by conflicting judicial constructions and repeated agency prosecutions." *Id.*, at 1001. The court concluded that the federal EPA and the state agency — although plainly different parties — were "sufficiently 'close' under the circumstances to preclude litigation of the issue already resolved in state court." *Id.*, at 1003. The Ninth Circuit emphasized that the basic facts and contentions were identical in both actions: "The interests of the [state] DOE and the [federal] EPA were identical and their involvement sufficiently similar." *Id; see Procter & Gamble Co. v. Byers Transp. Co.*, 355 F. Supp. 547, 556-58 (W.D. Mo. 1973) (shippers who were not parties to earlier proceeding are bound by ruling due to "joint interest" with plaintiffs in that case).

The Fifth Circuit in *Cauefield v. Fidelity and Casualty Co. of New York*, 378 F.2d 876 (5th Cir.), *cert. denied*, 389 U.S. 1009 (1967), applied Louisiana law to estop an action for cemetery desecration on the basis of a prior state court judgment involving different plaintiffs. Stressing that the second group of plaintiffs "admit that they can come forward with no evidence which was

not produced" at the first trial, the court concluded that "absolutely nothing would be gained" from the second lawsuit. *Id.*, at 879; *see Friedenthal v. General Ins. Co. of America*, 395 F.2d 202, 203 (5th Cir. 1968) (applying *Cauefield*, a husband's previous state-court judgment concerning automobile accident estopped wife in later suit for personal injuries from same accident). Similarly, in *Southwest Airlines Co. v. Texas Intern. Airlines*, 546 F.2d 84 (5th Cir.), *cert. denied*, 434 U.S. 882 (1977), numerous private plaintiffs were held estopped by a prior ruling in an action brought by a public agency. The Fifth Circuit concluded that the public entity had represented adequately "the only legal interests" that the private parties might assert in enforcement of certain regulations. *Id.*, at 97-98.

These courts have applied collateral estoppel based on the notion that a party's interests were sufficiently represented by a similarly-situated party in a prior proceeding against the common adversary. This reasoning also has supported collateral estoppel of nonparties in personal injury actions, *Urdiales v. St. Paul Mercury Insurance Co.*, 445 F.2d 296, 297 n.1 (9th Cir. 1971); *Ramos v. Horton*, 456 S.W.2d 565 (Tex. Civ. App. 1970), and in constitutional challenges to state statutes. *Midway Youth Football Ladies Aux. v. Strickland*, 449 F. Supp. 418, 423 (N.D. Ga. 1978) (Georgia law); *cf. General Foods v. Mass. Dept. of Public Health*, 648 F.2d 784 (1st Cir. 1981) (under Massachusetts law member of trade association bound by judgment to which trade association was a party). Numerous commentators have advocated preclusion of nonparties in such circumstances.[7]

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7. *See* Berch, "A Proposal to Permit Collateral Estoppel of Nonparties Seeking Affirmative Relief," 1979 *Ariz. St. L.J.* 511; George, "Sweet Uses of Adversity: *Parklane Hosiery* and the Collateral Class Action," 32 *Stan. L. Rev.* 655 (1980); Vestal, "The Restatement (Second) of Judgments: A Modest Dissent," 66 *Cornell L. Rev.* 464 (1981); Vestal, "Res Judicata/Preclusion: Expansion," 47 *S. Cal. L. Rev.* 357 (1974); Comment, "Nonparties and Preclusion by Judgment: The Privity Rule Reconsidered," 56 *Calif. L. Rev.* 1098 (1968); Note, "Preclusion of Absent Disputants to Compel Intervention," 79 *Colum. L. Rev.* 1551 (1979); Note, "Collateral Estoppel of Nonparties," 87 *Harv. L. Rev.* 1485 (1974); Comment, "Mandatory Intervention: Expansion of Collateral Estoppel in Favor of Single Defendants Against Multiple Plaintiffs In Federal Civil Litigation," 14 *John Marshall L. Rev.* 441 (1981).

B. Sound Judicial Policy Requires Collateral Estoppel of Nonparties Whose Interests Are Identical To The Interests Of Parties To The Previous Action When The First Proceeding Fully And Fairly Addressed The Issues

Despite these applications of collateral estoppel against nonparties, including *Montana v. United States*, *supra*, other courts have taken the wooden approach of the Third Circuit to deny collateral estoppel of nonparties. *E.g.*, *Wilson v. Attaway*, 757 F.2d 1227, 1237 (11th Cir. 1985); *Artrip v. Califano*, 569 F.2d 1298 (4th Cir. 1978).

The policies supporting collateral estoppel of nonparties were identified in *Montana*, *supra*, 440 U.S. at 153-54, which stressed that barring relitigation protects against "the expense and vexation attending multiple lawsuits, conserves judicial resources, and fosters reliance on judicial action by minimizing the possibility of inconsistent decisions."

This case concerns all of these policies, but raises most vividly the problem of inconsistent decisions. The federal decision takes the state court trial record, applies the same legal principles applied by the state court, and reaches exactly the opposite result. This sequence defeats the most basic expectations of a rational legal system. As Justice Sutherland wrote in enforcing res judicata against the federal government in *United States v. Moser*, 266 U.S. 236, 242 (1924), "a *fact*, *question* or *right* distinctly adjudged in the original action cannot be disputed in a subsequent action, even though the determination was reached upon an erroneous view or by an erroneous application of the law." (Emphasis in original.)

The first Justice Harlan addressed the principle more fully in *Southern Pacific R.R. v. United States*, 168 U.S. 1, 48-49 (1897), explaining that the "general rule" of collateral estoppel "is demanded by the very object for which civil courts have been established, which is to secure the peace and repose of society by the settlement of matters capable of judicial determination." Without that general rule, he warned, "the aid of judicial trials and tribunals would not be invoked for the vindication of rights of person and property." *Id.*

Putting such broad considerations aside, the outcome in this case will make it extremely difficult to manage a hospital. After the Third Circuit's ruling, no hospital can rely on Blue Cross and Medicare to reach the same result when they apply the same Medicare regulation to a single factual situation.

Moreover, relitigation in this case plainly has consumed unnecessarily the resources of the judicial system and of a hospital in a Chapter 11 reorganization. And application of collateral estoppel in this case is reinforced by "the value of federalism." *University of Tennessee v. Elliot*, 106 S. Ct. 3220, 3226 (1986). That value is undermined when a state-court judgment is so totally disregarded.

A central limitation on collateral estoppel, which is sometimes cast as a due process concern, is that the first proceeding must have provided a full and fair opportunity to litigate the issues involved. *Kremer v. Chemical Constr. Corp.*, 456 U.S. 461, 480 (1982). Unless the procedures of the first proceeding were fair and unless the issues were fully aired, collateral estoppel will not be justified. *Montana v. United States*, *supra*, 440 U.S. at 164 n.11; *United States v. ITT Rayonier*, *supra*, 627 F.2d at 1003.

But the Secretary has never claimed that the state court lawsuit was unfair or incomplete in its exploration of the Monsour conversion. Indeed, the Secretary could not take such a position because he adopted the factual record developed in the state court proceeding and did not seek an opportunity to develop new facts or to argue a new legal theory. All the Secretary wanted was a different outcome. Accordingly, there can be no serious claim that the Secretary's procedural rights would be compromised by barring relitigation of the state court judgment.

C. No Special Interest Of The Federal Government Bars Collateral Estoppel In This Case

This Court has recognized that the federal government as a litigant has obligations and policy objectives different from those of other litigants. The Court ruled in *United States v. Mendoza*,

464 U.S. 154 (1984), that an unappealed ruling won by certain parties in a previous lawsuit should not be collateral estoppel against the federal government in later actions brought by other parties. Because the Executive Branch may change its position due to political changes, and because this Court benefits from explorations of an issue by different lower courts, collateral estoppel cannot be invoked by a stranger to the initial proceeding against the government. *Id.*, at 160-61.

These considerations are irrelevant when the party seeking to estop the government was a party to the first judgment. *United States v. Stauffer Chemical Co.*, 464 U.S. 165, 173 (1984), announced on the same day as *Mendoza*, rejected the *Mendoza* rationale as a limitation on collateral estoppel "where the Government is litigating the same issue arising under virtually identical facts against the same party." Barring the government from relitigating the issue with that single party "still leaves [the government] free to litigate the same issue in the future with other litigants." *Id.*, at 173. That reasoning applies here. Because the hospital seeks only the benefit of a judgment to which it was a party, there is no danger of "freez[ing] the development of the law," *id.*, by applying collateral estoppel in the hospital's favor.

Moreover, relitigation before the PRRB cannot be allowed on the theory that the PRRB has a special competence in determining whether a hospital transaction was between related parties. The related parties issue does not involve questions of medical economics or complex regulations. Rather, it concerns corporate control, a familiar issue for common-law courts. *See Memorial, Inc. v. Harris*, 655 F.2d 905, 912 (9th Cir. 1980) (no deference to Secretary when reviewing "ordinary business transactions," rather than issues "demanding of medical or Medicare program expertise"). The state court in this case had the further advantage over the PRRB of hearing three weeks of testimony from the people involved in the Monsour conversion. There is no basis whatever for denigrating the competence of the

state court in this situation. *See Becher v. Contoure Laboratories, Inc.*, 279 U.S. 388 (1929) (state court judgment precludes subsequent patent lawsuit even though patent action could not have been brought in state court).

Finally, the Secretary asserts no public interest in this proceeding different from Blue Cross's interest in the state court action. Both Blue Cross and Medicare were acting as third-party payors under contracts with the hospital. No special public policy distinguishes Medicare's interest in the Monsour conversion from Blue Cross's interest.

II.
THE THIRD CIRCUIT'S DECISION ERRONEOUSLY EXPANDS THE RELATED PARTIES REGULATION AND DEFERS TO AN INCONSISTENT ADMINISTRATIVE INTERPRETATION

The court of appeals emphasized a single factor in the Monsour conversion in finding related parties present — that the completed conversion resembled the conversion as planned — and refused to consider the evidence that persuaded the state courts and the district court that there was no control by the Monsours of the Foundation or hospital. *See* p. 7, *supra*; Pet. App. B, at A-28 to A-30; Pet. App. E, at A-76 to A-83. By averting its eyes from this evidence, the Third Circuit converted the related parties regulation from a screen against self-dealing into a *per se* prohibition of transactions like this one.

Planning is essential to any complex financial transaction like the conversion of a hospital from proprietary to non-profit status. The Monsour conversion had to be approved by the Pennsylvania Attorney General, the Internal Revenue Service, and Blue Cross. Such a transaction as executed will, and should, closely resemble the planned transaction. The Foundation and hospital boards would not have exercised their powers responsibly if they had improvised and immediately adopted a conversion plan on the evening of May 17, 1975.

The Third Circuit's interpretation of the related parties rule has not been adopted by any other court. For example, in *Pacific*

Coast Medical Enterprises v. Harris, 633 F.2d 123 (9th Cir. 1980), a hospital purchase was negotiated and completed in two separate steps. Even though the completed transaction resembled the planned sale, and even though the final step of the transaction involved apparently related parties, the entire transaction was held not to have occurred between related parties. *Id.*, at 134-35. *Cf. Trusteees of Indiana University v. United States*, 618 F.2d 736 (Ct. Cl. 1980). Indeed, even courts finding related parties present in a hospital transaction have looked at "the circumstances surrounding the entire transaction." *Shaker Med. Center Hosp. v. Secretary*, 686 F.2d 1203, 1207 (6th Cir. 1982); *see Bellwood General Hosp. v. Schweiker*, 673 F.2d 1043 (9th Cir. 1982).

For most courts, the central issues under the related party regulations have been: (i) Whether one party dominated or had majority ownership of the board of the other party, *see Jackson Park Hosp. Foundation v. United States*, 659 F.2d 132, 134-35 (Ct. Cl. 1981); *American Hosp. Mgt. Corp. v. Harris*, 638 F.2d 1208 (9th Cir. 1981); and (ii) Whether one party had the ability to exercise daily authority over the health-care provider, *see Shaker Med. Center Hosp. v. Secretary*, *supra*, 686 F.2d at 1207-08; *Chelsea Community Hosp., SNF v. United States*, 2 Cl. Ct. 175, 180 (1983). The Monsour conversion satisfies these standards.[8]

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8. The Third Circuit suggested that the conversion resulted in "financial benefits [for the Monsours] far exceeding the real value of the hospital." Pet. App. A, at A-14. This totally unsupported assertion was never previously raised in the six years of litigation over the conversion. The court of appeals' sole citation for this unfortunate misstatement is Medicare's acceptance after the conversion of a valuation of the hospital of approximately $8 million for purposes of calculating reimbursement of depreciation. But the responsible Blue Cross official, Jackson Lynch, testified that the $8 million figure was not chosen to reflect the actual value of the hospital. Rather, Medicare's regulations required the setting for reimbursement purposes of the *lowest* of three options: "either the replacement [cost], the fair market [value] or the actual amount paid." Tr. 642 (Vol. VII); *see id.*, at 661-70. By adding the cash payment of $500,000 to the second mortgage of $7.5 million, the *lowest* possible valuation of the hospital was $8 million. That is what Medicare accepted for depreciation purposes, plus interest on the $3 million first mortgage. *Id.* Thus, Medicare's

The Third Circuit, however, adopted the PRRB's syllogism that a transaction that is completed as it has been planned necessarily involves related parties. In adopting this syllogism, the court of appeals purported to defer to the Secretary's interpretation of the related parties regulation as addressing only "the 'bona fides' of a sale *at the time of that sale*." Pet. App. A, at A-11 (emphasis in original).

But the Secretary's Guidelines in the Provider Reimbursement Manual contradict the Third Circuit and the Secretary's arguments below. In explaining the related parties regulation, § 1004.3 of the Manual states that "the facts and circumstances must be examined," and cautions that a reimbursement decision must represent "a conclusion based upon the entire body of facts and circumstances involved."

Moreover, in other cases the Secretary has opposed the Third Circuit's crabbed interpretation. In *Bellwood General Hosp. v. Schweiker*, *supra*, 673 F.2d at 1044, the hospital argued that the Secretary should consider "only the factors bearing on relatedness which existed before the hospital and the lessors entered into their agreement." The Ninth Circuit, however, adopted the Secretary's argument that it should look more broadly at hospital operations after the lease agreement was reached.

In *Hospital Dr. Tito Mattei*, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶34,869 (P.R.R.B. July 1, 1985), the Puerto Rico Secretary of Health appointed all of the board members of a new hospital in 1979, and that Board signed an agreement with the Puerto Rico Secretary to rent the hospital building. Nevertheless, the PRRB found that the Puerto Rico Secretary and the hospital were not related parties because there

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NOTES *(Continued)*

representative acknowledged that the replacement and fair market values of the hospital were greater than that amount. These facts provide no basis for the panel's suggestion of an unwarranted windfall for the Monsours. The Third Circuit's error on this point underlines the perils of fact finding by appellate courts. *Anderson v. City of Bessemer City, N.C.*, 105 S.Ct. 1504, 1512 (1985).

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was no evidence that the Puerto Rico Secretary "*exercised* control over the members of the board of directors" after their appointment. (Emphasis added.) The Secretary's designee affirmed, stating, "The fact that the [Puerto Rico] Secretary of Health selected the original members of the board of directors does not establish control . . . over the provider," since the board operated independently after it was appointed. [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶34,967 (HCFA Administrator Decision Aug. 27, 1985).

Indeed, in approving disallowance of the conversion-related expenses in this case, Medicare's Associate Regional Administrator claimed that the regulations had been violated because the Monsours had "effective control" of the hospital "both before *and after* the conversion." R. 2968 (emphasis added). Thus, Medicare itself recognized that related parties analysis cannot be restricted to the instant of the conversion, but must address all of the relevant circumstances.[9]

Courts should defer to agency interpretations only when those interpretations are consistent. *North Haven Board of Education v. Bell*, 456 U.S. 512, 522-23 n.12 (1982); *United Housing Foundation, Inc. v. Forman*, 421 U.S. 837, 858-59 n.25 (1975); *Southeastern Community College v. Davis*, 442 U.S. 397, 411-12 n.11 (1979). When the Secretary takes diametrically opposing positions in different proceedings solely to satisfy the exigencies of particular lawsuits, deference is misplaced.

By mistakenly deferring to an agency interpretation that has not been applied consistently, the Third Circuit ruling unjustifiably expands the related parties regulation. The result will be to prevent the sale or transfer of health-care facilities among parties known to each other, or the conversion of such facilities to non-profit status with payment to the former owners. Unless such transactions can be completed without planning, they are *per se* violations of the regulations as interpreted by the Third

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9. *See* Secretary's Br. at 11, *Medical Center of Tarzana v. Heckler*, No. 83-6077 (9th Cir. Dec. 16, 1985) (arguing that under related parties regulation, the lower court erred by ignoring record evidence concerning the operation of the hospital and "focus[ing] only on the *sale* and negotiations culminating in the sale")(emphasis in original).

Circuit. Since no other court has adopted the Secretary's syllogism, the impact of the related parties regulation now will depend solely upon the location of the health care provider. Such arbitrary variations in a vital national program like Medicare are unacceptable.

Finally, the Third Circuit's ruling contravenes basic principles of court review of agency adjudications under the "substantial evidence" standard set forth in the Medicare statute. 42 U.S.C. § 1395*oo*(f)(1); 5 U.S.C. § 706(2)(E). Court review of administrative decisions must be "searching and careful," *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971), and the courts must weigh all record evidence, including that which "fairly detracts from" the agency decision. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951). By refusing even to consider the evidence that detracted from the PRRB ruling, the Third Circuit failed to adhere to the controlling legal standard.

CONCLUSION

For all of the foregoing reasons, this Court should issue a writ of certiorari to the United States Court of Appeals for the Third Circuit.

Respectfully submitted,

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APPENDIX

APPENDIX A
806 F.2d 1185

MONSOUR MEDICAL CENTER, a non-profit organization,
Appellant/Cross-Appellee,

v.

Margaret HECKLER, Secretary of the Department of Health and Human Services, and Carolyne K. Davis, Administrator, Health Care Financing Administration,
Appellees/Cross-Appellants.

Appeal of MONSOUR MEDICAL CENTER.

Nos. 86-3168, 86-3191.

United States Court of Appeals,
Third Circuit.

Dec. 5, 1986.

As Amended Dec. 18, 1986.

Rehearing Denied January 6, 1987

Before ADAMS and HIGGINBOTHAM, Circuit Judges, and GARTH, Senior Circuit Judge.

OPINION OF THE COURT

A. LEON HIGGINBOTHAM, Jr., Circuit Judge.

These two appeals consider the proper treatment under the Medicare Act of interest and depreciation costs incurred by a health care provider in converting from for-profit to non-profit legal status, in providing hospital food services, and in operating a hospital snack bar. The district court, in an unpublished opinion,[1] entered summary judgment for appellant, the Monsour

1. *Monsour Medical Center v. Heckler*, No. 84-1938 (W.D.Pa. Dec. 30, 1985).

Medical Center ("Center") on the "conversion costs" issue. It found that the Provider Reimbursement Review Board ("PRRB" or "Board") decision denying reimbursement for these costs[2] was not supported by substantial evidence on the record, and remanded the matter to the PRRB "with instructions to properly reimburse [appellant] for these costs." Cross-Appellant, the Secretary of Health and Human Services ("Secretary"), appeals from this judgment. We will direct that the district court's award of summary judgment on this issue to the Center be vacated and that summary judgment be entered in favor of the Secretary. The district court also entered summary judgments for the Secretary, finding that the PRRB's decisions allocating certain dietary costs to the Center's nonreimbursable snack bar and denying reimbursement for employee snack bar meals were supported by substantial evidence. The Center appeals from these judgments. We will affirm these summary judgments of the district court.

FACTUAL BACKGROUND

This complicated story began, for our purposes, with the establishment in 1952 of a private hospital, the Monsour Hospital and Clinic, Inc. of Jeanette, Pennsylvania. The founders and sole shareholders of this Pennsylvania for-profit corporation were three brothers, Doctors Howard, Robert and Roy Monsour, and their parents. A fourth brother, Doctor William Monsour, became involved in this corporation at a later date. In 1966, subsequent to the passage of Title XVIII of the Social Security Act, 79 Stat. 291, as amended, 42 U.S.C. § 1395 *et seq*. (1982), commonly known as the Medicare Act, Robert, Roy and William Monsour, their mother, Eva Monsour, and their cousin, Doctor Omar Ayoub, created the Monsour Medical Foundation ("Foundation"), a Pennsylvania non-profit corporation. Their plan, soon realized, was for the Foundation to assume control of the hospital. On May 17, 1975, these five Monsour family members, who at that time owned all of the Monsour Hospital and Clinic stock, together sold 3.5 percent of this stock in their hospital to the Foundation for $500,000. At or about the same time,

2. *Monsour Medical Center v. Blue Cross & Blue Shield Ass'n/Blue Cross of W. Pa.*, PRRB Hearing Dec. No. 80-24 (June 14, 1984).

the family members donated an additional 46.7 percent of their outstanding stock, valued at $7,064,765, to the Foundation.[3] The hospital then redeemed the remaining 49.8 percent of its outstanding stock from these Monsour family members by signing a fifteen-year installment note of $7.5 million. Interest due on this note was, after the first five years,[4] pegged to the prime rate,[5] and the note was secured by a second mortgage on the hospital's real estate holdings. These three transactions, which left the Foundation as the sole stockholder in the hospital and the five Monsour family members as its mortgagees, constituted the financial aspects of the conversion. The hospital, now owned by the Foundation, was subsequently reorganized as a Pennsylvania non-profit corporation and renamed the Monsour Medical Center.

In addition to these financial complexities, this case also involves a web of corporate governing bodies. As the incorporators of and stockholders in the original for-profit hospital, the Monsour brothers sat on its corporate board and served as its corporate officers. Prior to the May, 1975 stock sale, donation and redemption, they resigned. The Foundation, at the May 19, 1975 meeting where it approved the conversion, appointed a

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3. There is some dispute between the parties as to the precise value of the hospital at the time of the conversion. A 1974 appraisal, commissioned by the hospital, valued its assets at $18 million. In 1977, a second appraisal put a market value of $6,419,500 on the real estate holdings of the Monsour Medical Center as of May 21, 1975. At a subsequent meeting with representatives of Blue Cross and Blue Shield of Western Pennsylvania, the Center accepted a valuation of $8.2 million as a basis for asset depreciation under Medicare. Although the Center now claims that the $8.2 million figure was "arbitrarily selected," Letter Brief of Appellant at 9 (Nov. 3, 1986), the record indicates that it is highly probative of what the stockholding members of the Monsour family actually were—and, more important, what they actually were *not*—"giving away" in the course of the 1975 conversion.

4. During the first five years of this note, the hospital made annual payments, including principal and interest at the rate of six percent, of more than $644,000.

5. When interest rates exploded in the inflationary economy of the late 1970s, the hospital's monthly interest obligation under this note at various times doubled and even tripled from the amounts it had previously been paying.

new hospital board and slate of officers consisting of no Monsour family members. In addition, five family members (Howard, Robert, Roy and William Monsour, and Ayoub) were the Foundation's original trustees, and they appointed the eight additional trustees who served with them as the Foundation Board of Directors. This Board subsequently created a six-member Executive Committee to oversee operations of both the Foundation and the Center.

For the hospital cost years in issue here, Blue Cross and Blue Shield of Western Pennsylvania ("Blue Cross") served as the government's fiscal intermediary under the Medicare program.[6] Until April, 1981, Blue Cross reimbursed the Center for the conversion-related interest and depreciation expenses; at that time, Blue Cross disallowed reimbursement for these expenses and reclaimed all such expenses it had previously paid to the Center, claiming that the conversion had not been an arm's length transaction between unrelated parties. The Secretary subsequently invoked this same reason for disallowing, in December, 1981, the reimbursement of appellant's conversion-related expenses. Appellant maintains that these actions affect "$2,117,842 in previously-reimbursed depreciation and interest expenses [for fiscal years 1977–1980] . . . [and] $1,560,482 in depreciation and interest expenses for [fiscal year] 1981." Brief

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6. Pursuant to contracts with the Secretary, such intermediaries provide reimbursement to Medicare service providers. *See generally* 42 U.S.C. § 1395h (1982 & Supp. II 1984 & Supp. III 1985). "As part of the[ir] fiscal responsibilities, these intermediaries [we]re required to ascertain the amount of reimbursement [that] accurately reflect[ed] the 'reasonable cost' of the Medicare services provided by an eligible health care institution. A final calculation as to reimbursable costs [wa]s made annually, at the close of the provider's fiscal year, and [wa]s based upon a 'cost report' that each provider [wa]s required to file. 42 C.F.R. § 405.–406(b)." *Northwest Hospital, Inc. v. Hospital Service Corp.*, 687 F.2d 985, 986 (7th Cir.1982).

For post-1983 cost years, this retrospective reimbursement system has been replaced by " 'prospective payment' for reasonable costs based on patient diagnoses." *Butler County Memorial Hospital v. Heckler*, 780 F.2d 352, 354 n. 1 (3d Cir.1985). *See also Washington Hospital Center v. Bowen*, 795 F.2d 139, 141–42 (D.C.Cir.1986).

for Appellant at 13. As a result, these actions in 1981 "reduced Medicare reimbursement to the [Center] by approximately $1,381,000." *Id.*[7]

Blue Cross, seeking both recovery of damages in the amount of its previous reimbursements for what it subsequently determined were not reimbursable costs and a declaratory judgment that the Center's conversion costs were as a matter of law not reimbursable under Medicare, sued the Center, the Monsour brothers and the Monsour Hospital and Clinic, Inc., the former owner of the Center, in Pennsylvania state court in 1982. These defendants filed counterclaims against Blue Cross seeking damages for defamation and a declaration that the conversion costs *were* reimbursable as a matter of law. After a three-week bench trial, the state court[8] declared in 1983 for the defendants that, because the hospital sale involved unrelated parties,[9] the conversion costs were reimbursable under the

7. The record does not clarify the basis for some of these figures. Nothing in our opinion turns on their precise magnitudes, however; we quote appellant's brief merely to convey a general flavor of the stakes in this dispute.

The precise facts concerning the intermediary's treatment of the food service and snack bar costs are wholly distinct from its treatment of the conversion costs and the litigation that ensued. They will therefore be set forth *infra*, in our review of the district court's determination of the propriety of the PRRB's holdings on those separate issues.

8. Hon. Martin I. Wekselman, Court of Common Pleas of Allegheny County, Pennsylvania.

9. The state court found that,

> [i]n essence, there [wa]s no evidence in this case from which [it could] find that the members of the [Foundation and hospital] Boards were in any way beholding to the Monsours by virtue of prior social, business or family relationships with them, and the fact of such relationships [wa]s insufficient alone or in combination with any or all of the other evidence in the case to support a finding such as that contended for by Blue Cross.

Blue Cross of W. Pa. v. Monsour Medical Center, No. GD 82–4968, at 33 (Pa.Ct. Common Pleas Feb. 2, 1983); Appellant's App. at A38. Its inquiry was focused upon the relationship between the Monsours and the Foundation since the conversion, however, and did not address the degree of control that was present in May, 1975. *See, e.g., id.* at 31; Appellant's App. at A36 (finding "as a fact from the evidence that *subsequent to the conversion*, control of the Foundation was in the Foundation Board and control of the hospital was in the hospital Board and that such control *remains*") (emphases added).

Medicare program through Blue Cross, the intermediary. *Blue Cross of W. Pa. v. Monsour Medical Center*, No. GD 82–4968 (Pa.Ct. Common Pleas Feb. 2, 1983).[10] Following the state court decision, the Secretary continued to disallow reimbursement for the Center's conversion-related costs. The Center then challenged the Secretary's refusal to reimburse by filing a complaint with the PRRB. On October 6 and 7, 1983, a PRRB hearing was held, as provided by statute, *see* 42 U.S.C. § 1395*oo*(a) (Supp. III 1985), to assess the Center's contentions on six distinct Medicare reimbursement issues. The PRRB found, *inter alia*, that the Foundation trustees who approved the conversion transactions

> were acting as surrogates of the [Monsour] family to implement the final stages of a corporate long-term plan [that] had been adopted by the Foundation in a prior period when it was controlled by the Monsour family. . . . There is no question that the Family, the Foundation, and the [hospital] were related when the entire transaction was specifically planned. The fact that the transaction was executed almost precisely as planned demonstrates the continuation of substantial control in fact.

Monsour Medical Center v. Blue Cross & Blue Shield Ass'n/Blue Cross of W. Pa., PRRB Hearing Dec. No. 80–24, at 20 (June 14, 1984); Appellant's App. at A64. This June 14, 1984 PRRB decision[11] was subsequently adopted by the Secretary, and the Center appealed the Board's adverse determinations to the district court.

DISCUSSION

Federal court jurisdiction to review a final decision of the PRRB affirmed by the Secretary is conferred by 42 U.S.C. § 1395*oo*(f)(1) (Supp. III 1985). Under the express terms of the Administrative Procedure Act ("A.P.A."), 5 U.S.C. §§ 551–59 & 701–06 (1982), the "action, findings, and conclusions" of such "an agency hearing provided by statute" are to be held "unlawful and

10. This decision was affirmed without opinion. *See Blue Cross v. Monsour Medical*, 341 Pa.Super. 610, 491 A.2d 914 (1985).

11. *See supra* note 2.

set aside" by the reviewing court if they are "unsupported by substantial evidence." 5 U.S.C. § 706(2)(E) (1982). "In making the foregoing determinations, the court shall review the whole record. . . ." *Id.* *Accord* 42 U.S.C. § 405 (1982) ("The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive. . . .").

We are, in effect, the second "appellate" court to consider the factual bases of PRRB's challenged findings. Our review applies, as did the district court's, the substantial evidence test. In an attempt to clarify the practical meaning of this test, we set forth the oft-quoted language of the Supreme Court:

> "[s]ubstantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." . . . Accordingly, it "must do more than create a suspicion of the existence of the fact to be established. . . . [I]t must be enough to justify, if the trial were to a jury, a refusal to direct a verdict when the conclusion sought to be drawn from it is one of fact for the jury."

Universal Camera Corp. v. NLRB, 340 U.S. 474, 477, 71 S.Ct. 456, 459, 95 L.Ed. 456 (1951) (citations omitted). *See also* *D & D Distribution Co. v. NLRB*, 801 F.2d 636, 638 (3d Cir.1986). The test

> requir[es] that the evidence be "substantial" after the reviewing court takes into account "whatever in the record [fairly] detracts from its weight." Thus, the evidence must be sufficient to support the conclusion of a reasonable person after considering the evidentiary record as a whole, not just the evidence that is consistent with the agency's finding.

R. Pierce, S. Shapiro & P. Verkuil, *Administrative Law & Process* 358–59 (1985) (quoting *Universal Camera*, 340 U.S. at 488, 71 S.Ct. at 465). Overall, this test is deferential, and we grant similar deference to agency inferences from facts if those inferences are supported by substantial evidence, "even [where] this

court acting *de novo* might have reached a different conclusion." *Hunter Douglas, Inc. v. NLRB*, 804 F.2d 808, 812 (3d Cir.1986) (citations omitted). Our review of an agency's interpretation of legal precepts, as demonstrated by its application of such precepts to the facts, is, of course, plenary. *See D & D Distribution Co.*, 801 F.2d at 638 (citing *Allbritton Communications Co. v. NLRB*, 766 F.2d 812, 817 (3d Cir.1985), *cert. denied*, ____ U.S. ____, 106 S.Ct. 850, 88 L.Ed.2d 891 (1986)). The Court's role in conducting such review "is not to impose its own interpretation of the . . . regulation, but instead to defer to [an agency's] position so long as it is reasonable." *Butler County Memorial Hosp. v. Heckler*, 780 F.2d 352, 355 (3d Cir.1985) (citing *Presinzano v. Hoffman-La Roche, Inc.*, 726 F.2d 105, 111 (3d Cir.1984)). In sum, so long as an agency's factfinding is supported by substantial evidence, reviewing courts lack power to reverse either those findings or the reasonable regulatory interpretations that an agency manifests in the course of making such findings of fact.[12]

A. *Conversion Costs*

Appellant Monsour Medical Center seeks Medicare reimbursement for the sizable interest expenses it incurred pursuant to its 1975 mortgage agreement with members of the Monsour family. It also seeks Medicare reimbursement, at a "stepped up" basis that reflects the price at which it purchased the hospital from Monsour family members in 1975, for its depreciation expenses since the conversion. The district court granted the Center's motion for summary judgment on these issues, and the Secretary, as cross-appellant, now appeals from that portion of

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12. In this regard, a reviewing court must be careful not to let its policy views as to the merits of a particular regulatory interpretation affect the stringency of the substantial evidence test it applies to the factual findings of an agency advancing such an interpretation. Placing such a judicial "thumb" on the reviewing "scale" would exceed the proper appellate role delineated by the A.P.A.

the district court's order. At issue in this cross-appeal are reimbursement claims dating back to fiscal year 1977. To assess the validity of the PRRB's treatment of these claims, we turn first to the applicable federal regulations.

According to the Medicare regulations, a health care provider's interest expenses are an allowable cost (i.e., reimbursable) if they are "paid to a lender not related through control or ownership, or personal relationship to the borrowing organization." 42 C.F.R. § 405.419(b)(3)(ii) (1985). As to determining the proper cost basis of a provider (i.e., the purchase price figure from which its depreciation costs are to be calculated), the regulations provide that, "[i]f the purchaser cannot demonstrate that the sale was bona fide, . . . [its] cost basis shall not exceed the seller's cost basis, less accumulated depreciation."[13] 42 C.F.R. § 405.415(g)(3)(1985). For both determinations,[14] the crucial inquiry concerns the relationship between the Foundation and the Monsour family (i.e., the buyer and the seller of the hospital facility). The "related organizations" provision, 42 C.F.R. § 405.427 (1985),[15] which provides for the allowance of

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13. While this regulation offers no definition of a "bona fide" sale, another of its subparts does refer to the definition of "a transaction between related organizations, as defined in § 405.427 . . ." 42 C.F.R. § 405.415(d)(3)(ii)(A) (1985). Without additional guidance from Congress or the relevant agency, we thus feel constrained to assume—and reasonable in assuming—that a bona fide sale for purposes of determining the cost basis of a Medicare provider is one transacted between organizations that are not "related" under § 405.427.

14. *See supra* note 13.

15. As courts have previously noted, this regulation "serves to screen out both costs not actually incurred and unreasonable costs. That is to say, the regulation precludes reimbursement for cost increases due solely to transactions between different parts of a single economic unit, and it polices 'sweetheart' contracts with suppliers that may inflate costs to the provider." *Medical Center of Independence v. Harris*, 628 F.2d 1113, 1119 (8th Cir.1980). *See also Fairfax Hosp. Ass'n, Inc. v. Mathews*, 459 F.Supp. 429, 433 (E.D.Va.1977) (the regulation "merely denies a double profit to a firm which is, in effect, dealing with itself"), *aff'd sub nom. Fairfax Hosp. Ass'n, Inc. v. Califano*, 585 F.2d 602 (4th Cir.1978). Other Medicare regulations that have imported the definitions of § 405.427(b), such as those at issue in this cross-appeal, seek to

certain costs incurred by a provider's "relatives," offers these definitions of "organizations related to the provider by common ownership or control:"

> (b) *Definitions*—(1) *Related to provider*. Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities or supplies.
>
> (2) *Common ownership*. Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.
>
> (3) *Control*. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

Id. Applying this precise definition of "control" as the governing legal precept in this matter, we will hold that substantial evidence on the record supported the PRRB's finding that the Foundation and the Monsour family were related parties at the time of the conversion.

1. *The Governing Legal Precepts*

The PRRB and the district court, in their respective analyses of these reimbursement issues, disagreed fundamentally on the proper application of the relevant Medicare regulations. In assessing the "relatedness" of the Monsour family and the Foundation, the Board looked to "the corporate long-term planning period."[16] *Monsour Medical Center v. Blue Cross & Blue Shield Ass'n/Blue Cross of W. Pa.*, PRRB Hearing Dec. No. 80-24, at 20 (June 14, 1984); Appellant's App. at A64. The district court,

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prevent the potentially huge payoffs that could otherwise result from a care provider's self-dealing.

While this appeal was pending, this provision was recodified at 42 C.F.R. § 413.17. *See* 51 Fed.Reg. 34, 797-98 (1986).

16. This period covers roughly the years 1969-1975, the time it took the Foundation to realize its goal of purchasing the Monsour Health Center.

by contrast, believed that focusing on that earlier time period "beg[ged] the issue, i.e., whether the Monsours continued to control the Center *after* the sale." *Monsour Medical Center v. Heckler*, No. 84-1938, at 11 (W.D.Pa. Dec. 30, 1985); Appellant's App. at A79. Although the regulations—like the analyses of the issue by both the PRRB and the district court—lack ideal clarity, we will accept the PRRB's interpretation of them.

The regulation governing depreciation, although it does not speak of control or relatedness,[17] requires a purchaser of a care providing facility to demonstrate "that the sale was bona fide." 42 C.F.R. § 405.415(g)(3) (1985). We interpret this regulation as addressing the "bona fides" of a sale *at the time of that sale*. The regulation governing interest costs "paid to a lender . . . [by] the borrowing organization" does speak of "control," "personal relationship" and "related[ness]." 42 C.F.R. § 405.419(b)(3)(ii) (1985). We interpret this regulation as addressing, though less clearly than the previous regulation, the "control," "personal relationship" and "related[ness]" of parties to a loan *at the time of their borrowing and lending*. So far as we can ascertain from its hearing decision, these were and are the PRRB's interpretations of its governing regulations.[18] As a reviewing court constrained by the A.P.A., "[w]e must . . . accept the agency's view so long as the 'interpretation[s are] within the range of reasonable meanings that the words of the regulation[s] admit.' "[19] *Butler County Memorial Hospital*, 780 F.2d at 355–56 (quoting *Psychiatric Institute of Washington, D.C., Inc. v. Schweiker*, 669 F.2d 812,

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17. *See supra* note 13.

18. *See, e.g., Medical Center of Independence*, 628 F.2d at 1116 ("The PRRB[, applying 42 C.F.R. § 405.427 (1979),] . . . conclud[ed] that [the care provider] had introduced substantial evidence that it and [the organization to which the provider paid interest, rent and management fees] were not related *at the time that they entered into their agreement*. . . .") *(emphasis added)*.

19. Even when an agency is in some sense "guilty" of promugating ambiguous regulations, we nonetheless defer to its reasonable interpretations of them. *See Modine Mfg. Corp. v. Kay*, 791 F.2d 267, 273–74 (3d Cir.1986).

813–14 (D.C.Cir.1981) (per curiam)).[20] Based on our own reading of the regulatory language, we conclude that the Secretary's apparent interpretations are plainly reasonable. In these circumstances, where there is no evidence that accepting the

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20. *See also United States v. Larionoff*, 431 U.S. 864, 872, 97 S.Ct. 2150, 2155, 53 L.Ed.2d 48 (1977) ("We need not tarry . . . over the various ambiguous terms and complex interrelations of the [Defense Department] regulations. In construing administrative regulations, the 'ultimate criterion is the administrative interpretation, which becomes of controlling weight unless it is plainly erroneous or inconsistent with the regulation.' ") (quoting *Bowles v. Seminole Rock Co.*, 325 U.S. 410, 414, 65 S.Ct. 1215, 1217, 89 L.Ed. 1700 (1945)); *United States v. Hescorp, Heavy Equipment Sales Corp.*, 801 F.2d 70,76 (2d Cir.) (the views of the administering agency "are entitled to substantial deference[,] . . . especially [where that agency] participated in developing the subject [r]egulations"), *petition for cert. filed*, 55 U.S.L.W. 3372 (U.S. Nov. 25, 1986) (No. 86–760); *Grier v. Secretary of Army*, 799 F.2d 721, 725–26 (11th Cir.1986) ("As this agency interpretation is not at odds with the text of the regulation, or plainly erroneous, it is entitled to great deference by this court."); *United Transportation Union v. Dole*, 797 F.2d 823, 828 (10th Cir.1986); *Sioux Valley Hosp. v. Bowen*, 792 F.2d 715, 719 (8th Cir.1986); *accord Udall v. Tallman*, 380 U.S. 1, 4, 85 S.Ct. 792, 795, 13 L.Ed.2d 616 (1965) (interpreting executive orders) ("The Secretary's interpretation[s] may not be the only one[s] permitted by the language of the [regulations], but [they are] quite clearly . . . reasonable interpretation[s]; courts must therefore respect [them].") (citing *Bowles*, 325 U.S. at 413–14, 65 S.Ct. at 1217, and *McLaren v. Fleischer*, 256 U.S. 477, 481, 41 S.Ct. 577, 578, 65 L.Ed. 1052 (1921)); *Wheeler v. Heckler*, 787 F.2d 101, 104 (3d Cir.1986) ("because Congress had delegated to the Secretary the responsibility for administering . . . complex [Social Security] programs, we must defer to her [statutory] construction, as long as it is reasonable and not arbitrary and capricious"); *cf. Lugo v. Schweiker*, 776 F.2d 1143, 1148 (3d Cir.1985) (where a statute does not indicate what Congress intended, that "this Court must defer to the secretary's reasonable interpretation . . . [is a] basic principle of administrative law and statutory construction"); *Chrobal Metro Life Ins. Co.*, 517 F.2d 883, 886 (7th Cir.1975) (words should be given their ordinary meaning, "particularly . . . [when they] are found in a promulgated governmental regulation"); *Garner v. United States Office of Personnel Management*, 633 F.Supp. 995, 999 (E.D.Pa.1986) ("the [degree of] deference a court should give to an agency's construction[s] of its regulations . . . is directly proportional to the complexity of the statutes and regulations involved based upon the expertise developed by the agency in adminstering [them]").

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Secretary's interpretive expertise will actually "shield an irrational decision-making process," *Natural Resources Defense Council, Inc. v. EPA*, 790 F.2d 289, 298 (3d Cir.1986), or "work[ ] an unduly harsh result in the name of an otherwise valid and laudable regulation," *Hart v. Bowen*, 799 F.2d 567, 570 (9th Cir.1986), there is no basis for second-guessing the agency. The district court therefore erred as a matter of law in replacing these interpretations, which are "completely within the range of reasonable meanings [that] may logically . . . be drawn from the words of the regulation[s]," *Garner v. United States Office of Personnel Management*, with its own views.

2. *Substantial Evidence Review*

We now address the question the district court did not reach:[21] Was the PRRB's finding that the Monsour family and the Foundation—the seller and the buyer—were related parties at the time of the 1975 conversion[22] based on substantial evidence?[23] We answer this question unequivocally and in the firmative.

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21. Based on its erroneous interpretations of the government regulations, the district court, in its analysis and in its extensive quotations from Judge Wekselman's state court opinion, addressed the question whether members of the Monsour family and the Foundation have been related parties *since* the date of the conversion. *See, e.g., Monsour Center v. Heckler*, No. 84–1938, at 8–11 (W.D.Pa. Dec. 30, 1985); Appellant's App. at A76–A79.

22. On its way to reaching this conclusion, the Board offered the following syllogism:

> The Monsour family and the Foundation (both its board and its trustees) were related parties at the time the conversion was planned (roughly 1969-1974). In 1975, the conversion went exactly as they had previously planned. Therefore, they must have been related parties at the time of the conversion.

See Monsour Medical v. Blue Cross & Blue Shield Ass'n/Blue Cross of W. Pa., PRRB Hearing Dec. No. 80–24, at 20 (June 14, 1984); Appellant's App. at A64. This analysis assumes, of course, that relatedness is essential to a conversion occurring as it has been planned. We look to the record evidence on which the Board based its finding, without assessing the logical validity of this syllogistic "explanation."

23. Because we conclude that the PRRB's determination was based upon substantial evidence, we do not address the validity of what the district court—correctly, as we read the PRRB's decision—took to be the PRRB's "alternative

The Medicare statute defines related organizations in terms of "control," which "exists where an individual or an organization has the power, directly *or indirectly*, significantly to influence or direct the actions or policies of an organization or institution." 42 C.F.R. § 405.427(b)(3) (1985) (emphasis added). Virtually all the factual evidence in the record before the PRRB establishes that the creation of the Foundation, the selection of its board members and trustees, and the financial transactions that effectuated the hospital conversion all proceeded according to the plans of, and were executed by, the members of the Monsour family who were the hospital's original (and only) stockholders. The record indicates that they planned a series of transactions that would produce for them financial benefits far exceeding the real value of the hospital they were selling to the Foundation.[24] The record also indicates that the Monsour family members, after setting the terms of the conversion, expanded the Foundation they had created by adding eight new members appointed for the purpose of approving the conversion; in fact, while the four Monsours abstained from voting, this new "non-Monsour" majority Foundation did approve every aspect of the proposed conversion. The record thus indicates that the conversion went exactly as the Monsour family members, as both the selling stockholders and the buying Foundation, had planned. Complicated organizational and financial structures simply cannot conceal or negate such substantial record evidence of the Monsours' direct power significantly to influence the actions or policies of the Foundation at the time of the conversion.[25] While

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basis" for disallowing reimbursement of the Center's interest costs: the assertion that costs incurred purchasing stock that is not related to patient care are not reimbursable. *See Monsour Medical Center v. Blue Cross & Blue Shield Ass'n/Blue Cross of W. Pa.*, PRRB Hearing Dec. No. 80-24, at 21 (June 14, 1984); Appellant's App. at A65.

24. *See supra* note 3.

25. In reaching the opposite conclusion, the district court, like Judge Wekselman in the state court proceeding, apparently gave overwhelming weight to record evidence that since the 1975 conversion Monsour family members have not called the shots in all aspects and areas of the Center. Such

the substantial evidence just described is sufficient to demonstrate direct power to control, it in addition—and without question—demonstrates that the Monsour family at least had the *indirect* power, referred to in the regulations, "significantly to influence or direct the actions or policies" of the Foundation at the time of the conversion. 42 C.F.R. § 405.427(b)(3) (1985). The district court erred in finding otherwise. It looked only at events subsequent to the conversion, and it appears simply to have ignored the PRRB's finding that the precise facts of the conversion itself, because it was carried out as planned when the Monsours *were* the Foundation, were powerful and substantial evidence of the Monsours' continuing power to influence the Foundation at the time in question. We will therefore vacate the district court's summary judgment for the Center as to the conversion costs and order that the district court enter summary judgment for the Secretary on this issue.

3. *Collateral Estoppel*

In the state court action involving Blue Cross and the Center, Judge Wekselman addressed appellant's claim "that evidence supports a finding that the conversion which occurred in May of 1975 was an arm's length transaction within the guidelines established by the Medicare regulations."[26] *Blue Cross of W. Pa. v. Monsour Medical Center*, No. GD 82–4968, at 7 (Pa.Ct. Common Pleas Feb. 2, 1983); Appellant's App. at A12. He found that,

> [i]n essence, there is no evidence in this case from which the Court can find that the members of the two Boards were in any way beholding to the Monsours by virtue of prior social, business or family relationships with them, and the fact of

evidence, while interesting, is not material to the legal issue before us: the control Monsour family members exercised over the Foundation *at the time of the conversion*.

26. In the state proceeding, the parties agreed "that the Medicare regulations govern the determination of that question and dictate whether the disputed costs are reimbursable by Blue Cross in either of its reimbursing capacities." *Blue Cross of W. Pa. v. Monsour Medical Center*, No. GD 82–4968, at 7 (Pa.Ct. Common Pleas Feb. 2, 1983); Appellant's App. at A12.

> such relationships is insufficient alone or in combination with any or all of the other evidence in the case to support a finding such as that contended for by Blue Cross.

Id. at 33; Appellant's App. at A38. Appellant, as cross-appellee on this issue, urges us, as it urged both the PRRB and the district court, to consider ourselves governed by this state court finding.

While Blue Cross was a party to the state proceeding, the Secretary was not. Therefore, to estop the federal government from litigating its claims, appellant would have to prove that "the United States exercised control" over Blue Cross's Pennsylvania court suit against the Center. *Montana v. United States,* 440 U.S. 147, 155, 99 S.Ct. 970, 974, 59 L.Ed.2d 210 (1979). In *Montana,* where this question of control by the United States was not in dispute due to stipulations of the United States, *see id.,* the Supreme Court based its finding that the United States had controlled the prior state suit, and thus was precluded from relitigating the issues that that state suit had settled, on the following indicia:

> [t]he government . . .
>
> (1) required the [state] lawsuit to be filed;
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> (2) reviewed and approved the complaint;
>
> (3) paid the attorneys' fees and costs;
>
> (4) directed the appeal from State District Court to the [State] Supreme Court;
>
> (5) appeared and submitted a brief as *amicus* in the [State] Supreme Court;
>
> (6) directed the filing of a notice of appeal to [the United States Supreme] Court; and
>
> (7) effectuated [the state court plaintiff's] abandonment of that appeal on advice of the Solicitor General.

Id. In the state suit that preceded this case, the Secretary played *none* of these controlling roles. The fact that she was sufficiently satisfied with the probative value of the state court proceeding to

submit its transcript as evidence in the PRRB hearing does not, at least not without certain proof of the *Montana* indicia just enumerated, prove "plainly [that the Secretary] had a sufficient 'laboring oar' in the conduct of state court litigation to actuate principles of estoppel."[27] *Id.* (quoting *Drummond v. United States*, 324 U.S. 316, 318, 65 S.Ct. 659, 660, 89 L.Ed. 969 (1945)). We therefore agree with the PRRB and the district court[28] that the state court findings in the Blue Cross-Monsour Medical Center suit should not be given legally preclusive effect in this federal action.[29]

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27. Because plain evidence of Government control is lacking, we do not undertake the further inquiries that would also be required before we could hold the Government estopped by the state court finding, to wit:

> first, whether the issues presented by this litigation are in substance the same as those resolved against the United States in [state court]; second, whether controlling facts or legal principles have changed significantly since the state-court judgment; and finally, whether other special circumstances warrant an exception to the normal rules of preclusion.

Montana, 440 U.S. at 155, 99 S.Ct. at 974–75.

28. We note that the district court, while rejecting appellant's collateral estoppel argument, did give Judge Wekselman's state court findings considerable weight in concluding that the PRRB's finding of "relatedness" was not supported by substantial record evidence. In effect, it seems, the district court believed that the government was almost estopped by the prior state court finding, and let this belief guide its substantial evidence review. Such an approach confuses distinct legal analyses in a way that adversely affects the clarity and accuracy of each. Once the district court found that the state court findings should not be given preclusive effect in this case, those findings ceased to be directly relevant to the district court's review of the Board's findings; the fact that the state court, on the basis of some of the same evidence, previously reached an opposite conclusion from the Board's does not as a matter of federal law make the record evidence upon which the Board relied any less substantial in the eyes of a reviewing court.

29. Appellant also contends that we are bound by the doctrine of *stare decisis* to respect the state court's determinations. Like the district court, we are not persuaded by this unusual assertion, for *stare decisis* concerns the deference and respect a given court must show *its own* prior decisions or those of its superior(s). *See, e.g., City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 419–20 & n. 1, 103 S.Ct. 2481, 2487 & n. 1, 76 L.Ed.2d 687 (1983) (the Supreme Court demonstrating its respect for the doctrine by reaffirming *its* decision in *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705,

4. *Equitable Estoppel*

Five years passed and actual reimbursement was paid for the Center's conversion costs before Blue Cross audited the Center's cost reports and retroactively disallowed these reimbursements. Appellant contends that the Secretary should therefore be equitably estopped from changing the original course of conduct.

Appellant has failed to carry its sizeable burden of proof on this issue.[30] In *Heckler v. Community Health Services of Crawford County, Inc.*, 467 U.S. 51, 104 S.Ct. 2218, 81 L.Ed.2d 42 (1984) ("*Crawford County*"), the Supreme Court unanimously rejected a similar claim by a Medicare provider that had benefitted from excessive reimbursements provided by the Secretary's intermediary. Appellant has failed to demonstrate that the denial of reimbursement for the interest and depreciation costs associated with its conversion leaves it "significantly worse off than if it had never obtained" such reimbursement in the first place. *Id.* at 63, 104 S.Ct. at 2225. In fact, like the health care provider in *Crawford County*, the Center here has demonstrated no detriment other than its "inability to retain money that [the Secretary has now determined] it should never have received in the first place." *Id.* at 61, 104 S.Ct. at 2225. The core teaching of *Crawford County* is that, in the context "of a complex

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35 L.Ed.2d 147 (1973)); *Horn v. Kean*, 796 F.2d 668, 671 (3d Cir.1986) (in banc) ("the doctrine of *stare decisis* . . . requires inferior courts to follow decisions of a superior court").

30. We note, but do not rely upon, the recent declaration of eight Supreme Court Justices that it is still only an "assum[ption] that the Government is *ever* subject to estoppel." *Lyng v. Payne*, ___ U.S. ___, 106 S.Ct. 2333, 2340, 90 L.Ed.2d 921 (1986) (emphasis added). *Cf. id.*, 106 S.Ct. at 2345 n. 2 (Stevens, J., dissenting) ("To its credit, in rejecting the Government's [sic] equitable estoppel argument, the Court belatedly acknowledges that it unnecessarily prolonged this litigation by vacating the first judgment entered by the Court of Appeals in 1983 and remanding for further consideration in light of our [equitable estoppel doctrine] decision in *Heckler v. Community Health Services [of Crawford County, Inc.]*, 467 U.S. 51, 104 S.Ct. 2218, 81 L.Ed.2d 42 (1984)."); *United States v. Locke*, 471 U.S. 84, 105 S.Ct 1785, 1802, 85 L.Ed.2d 64 (1985) (O'Connor, J., concurring) ("our previous decisions would not necessarily bar application of the doctrine of equitable estoppel").

program such as Medicare," it is simply too much to expect the Government "to ensure that every bit of informal advice given by its agents . . . will be sufficiently reliable to justify expenditure of sums of money as substantial as those spent by [appellant]." *Id.* at 64, 104 S.Ct. at 2226. Adhering to that teaching, we find that equitable estoppel of the Secretary is not justified on the facts of this case.

B. *Dietary Cost Reclassification*

In its Medicare cost reports filed with Blue Cross for fiscal year 1980, the Monsour Medical Center correctly treated its dietary costs (including its employee cafeteria) and its snack bar costs as separate "cost centers." Appellant's cost report claimed the snack bar as a non-reimbursable cost center. Blue Cross subsequently audited the report and discovered that some nonreimbursable snack bar costs had been reported in the reimbursable dietary/cafeteria cost center. It thus reclassified those costs to the snack bar cost center (i.e., it refused to reimburse them). It also reopened the Center's cost reports for fiscal years 1977 through 1979 and adjusted them in the same way. Because the Center was unable to verify its claims that its original reports were accurate, Blue Cross made these adjustments in reliance on data provided by an outside contractor who had operated the cafeteria and had ordered, stored and assembled the food that was ultimately transferred to and served by the snack bar.

The Center appealed these reclassification adjustments (approximately $318,000) to the PRRB, which found them to be appropriate. *Monsour Medical Center v. Blue Cross & Blue Shield Ass'n./Blue Cross of W. Pa.*, PRRB Hearing Dec. No. 80-24, at 18 (June 14, 1984); Appellant's App. at A62. The Board found that the Center had failed "to maintain verifiable and auditable financial records and statistical data to support [its] costs claimed," as required by 42 C.F.R. §§ 405.406 and 405.453 (1985). *Id.* It therefore concluded that Blue Cross's resort to data furnished by the outside contractor was "reasonable and responsible[;] . . . [it was] an acceptable alternative in view of the [Center's] deficient . . . records." *Id.* The district court concluded that

the Board's approval of the cost reclassifications was based upon substantial evidence,[31] and the Center now appeals.

We will affirm this portion of the district court's summary judgment order for appellee. The Center disputes the accuracy of the contractor's data, and it has urged this court to consider the Center's own study finding that snack bar meals in fact cost much less than Blue Cross's reclassification indicates, but it has offered no defense of its recordkeeping. Substantial evidence indicates that the Center's records for the years in question do not contain accurate data "in sufficient detail" to support its claims for dietary cost reimbursement. 42 C.F.R. § 405.453(c) (1985).

C. *Snack Bar Meal Costs*

Before the PRRB, the Center also challenged Blue Cross's refusal to reimburse its snack bar costs that relate to providing employee meals. The Board upheld this refusal, again basing its decision on the inadequacy of the Center's records to support its reimbursement claims.[32]

We will affirm the district court's entry of summary judgment for the Secretary on this issue. We agree with the district court that the record before the Board "[d]id not establish with

31. The district court did not analyze this issue independently. Instead, its opinion merged this question with the question whether the Center should be reimbursed for snack bar costs attributable to employee meals. We prefer to treat these questions separately, and have structured this opinion accordingly.

32. The Center did offer the Board a 1981 study of employee snack bar utilization, and urged the Board to use this study data to estimate unrecovered employee meal costs for the prior cost reporting periods at issue. As to 1981, the Board found that the Center's records were inadequate to corroborate the study's conclusions that 65 percent of the snack bar's activity related to employee utilization. The Board also found that—because snack bar revenue and costs statistics varied widely and without explanation from year to year, because the Center's snack bar records were commingled with those of its gift shop for all the years in question, and because 1981 was the first year in which cafeteria and snack bar services were combined after the services of the outside contractor were discontinued—there was no reasonable basis to extrapolate the findings of the 1981 study back to the prior years. *See Monsour Medical Center v. Blue Cross & Blue Shield Ass'n/Blue Cross of W. Pa.*, PRRB Hearing Dec. No. 80-24, at 18 (June 14, 1984); Appellant's App. at A62.

the required degree of accuracy the snack bar costs attributable to employee meals during the years in question."[33] The Center must bear the cost of its failure to maintain the records required of a Medicare provider.

CONCLUSION

On the conversion cost issue, we will vacate the district court's summary judgment for the Center and will direct the district court to enter summary judgment for the Secretary. On the dietary cost center and snack bar meal cost issues, we will affirm the district court's entry of summary judgment for the Secretary.

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33. We thus become the third court to note that "[t]he hospital's record keeping might most charitably be characterized as chaotic." *Blue Cross of W. Pa. v. Monsour Medical Center*, No. GD 82-4968, at 15 (Pa.Ct. Common Pleas Feb. 2, 1983); Appellant's App. at A20.

APPENDIX B

[1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,083
MONSOUR MEDICAL CENTER,
Plaintiff
v.
MARGARET M. HECKLER,
Secretary of Health and Human Services,
Defendant.
Civ. A. No. 84-1938
United States District Court
W.D. Pennsylvania
December 30, 1985

OPINION

ZIEGLER, District Judge

Plaintiff, a health care facility in Jeannette, Pennsylvania, seeks review of the refusal of the Secretary of Health and Human Services to provide Medicare funds to the facility for certain claimed reimbursable costs. Jurisdiction is based on section 1878(f)(1) of the Social Security Act, 42 U.S.C. § 1395oo(f)(1).

Monsour Medical Center presents four claims for reimbursement, dating from 1977. They are: $1,381,000 plus interest for costs relating to the 1975 conversion of the Center from a profit to a non-profit status; $318,000 for employee meals and operation of the snack bar; $48,000 for the operation of three publicly-funded programs, and $60,000 for the cost of malpractice insurance.

The civil action is an appeal from the decision of the Provider Reimbursement Review Board (PRRB), dated June 14, 1984, which denied reimbursement for these costs. The Secretary adopted the Board's findings, thereby permitting plaintiff to appeal the decision to this court. 42 U.S.C. § 1395oo(f)(1). Both parties have moved for summary judgment.

I. Standard of Review

This court is empowered to review final decisions of the Secretary utilizing the scope and standard of review set out in the Administrative Procedure Act, 5 U.S.C. §§ 701-06. We must "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law . . . . or unsupported by substantial evidence." 5 U.S.C. § 706(2)(A)(E). *Home Health Services v. Schweiker*, 683 F.2d 353, 356 (11th Cir. 1982). Substantial evidence means such relevant evidence that a reasonable mind might accept as adequate to support a conclusion. *Cotter v. Harris*, 642 F.2d 700, 704 (3d Cir. 1981). Our task is to review the evidence presented to the PRRB and determine whether its findings are supported by substantial evidence.

II. History of Case

Monsour Medical Center is a 233-bed, acute-care hospital in Jeannette, Pennsylvania. The Center was established in 1959 by four Monsour brothers, each of whom was a physician. As the hospital grew in the early 1970's, and as the cost of operating a for-profit medical facility increased, the brothers as founders and members of the Monsour Medical Foundation determined to convert the hospital into a non-profit institution and receive Medicare reimbursements. The transfer had to be made through unrelated parties for the costs associated with the conversion to be reimbursed through Medicare. 42 C.F.R. § 405.427(b). Aware of this requirement, the Monsour Medical Foundation retained two Pittsburgh attorneys to structure a conversion to satisfy the Medicare regulations.

In May 1975, the conversion to a non-profit hospital was effected. From the evidence of record, the major concern in the conversion was to keep the Monsours involved in the operation of the hospital without Medicare determining that the transfer of control was a transfer between related parties. As defined in 42 C.F.R. § 405.427(b)(1), related to the provider "means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies." The eventual solution included

expanding the number of Foundation members from five to the present thirteen. In this way, the Center argues, the Foundation was no longer controlled by the four Monsour brothers and, therefore, not related for Medicare purposes to the former ownership of the Center. For the conversion, the Monsour brothers exchanged 100 percent of their interest in the facility in exchange for cash and a second mortgage.

The evidence of record establishes that the Internal Revenue Service, agencies of the Commonwealth of Pennsylvania and the hospital's intermediary, Blue Cross of Western Pennsylvania, approved the structure before the conversion. It appears that Blue Cross was skeptical of the arrangement and periodically audited the reconstituted Foundation to ensure that the brothers did not retain control of the hospital. Apparently, the audits did not reveal any hidden benefits or control by the Monsour brothers. The costs of conversion, including depreciation of the assets of the Foundation and interest costs, initially were deemed as reimbursable expenses for which Medicare payments were received.

According to plaintiff, Blue Cross continued reimbursement of the conversion-related expenses for six years, until April 1981. At that time, Blue Cross disallowed reimbursement of these expenses and reclaimed all such expenses previously paid. As grounds for this action, Blue Cross claimed that the conversion was not an arm's length transaction. Plaintiff states that Medicare then disallowed the conversion-related expenses on the same basis in December 1981. It is alleged that these actions reduced the Medicare reimbursement to the hospital by approximately $1,381,000.

To recover damages and obtain a declaration that the conversion costs were non-reimbursable, Blue Cross filed a five-count complaint in the Court of Common Pleas of Allegheny County, Pennsylvania, in 1982. Neither Medicare nor the Social Security Administration was a party to the lawsuit. The defendants included the Center, the Monsour brothers and the hospital's former owner, Monsour Hospital and Clinic, Inc. The defendants filed a counterclaim, seeking damages for defamation and a declaration that the conversion costs were reimbursabl-

Following an exhaustive examination of the conversion in a three-week trial, the Honorable Martin I. Wekselman ruled that the sale was consummated by unrelated parties and that the costs of conversion were reimbursable through Blue Cross. The Superior Court of Pennsylvania affirmed the decision without opinion in *Blue Cross of Western Pennsylvania, Inc. v. Monsour Medical Center,* 491 A.2d 914 (Pa.Super.Ct. 1985).

Following the decision of the trial court, Medicare continued to disallow the costs of conversion as reimbursable expenses. In addition, Medicare determined that the costs associated with the snack bar at the Center, staff malpractice insurance payments and other program costs were not reimbursable for various reasons. Pursuant to the Social Security Act, a hearing was held before the PRRB. The administrative body determined that the above costs were not reimbursable for the following reasons: the costs of conversion were generated between related parties and were not the result of an arm's-length bargain; depreciation and interest costs were not reimbursable because the transaction represented a sale of stock, not of assets; the amount of "reasonable and necessary" costs associated with the snack bar could not be determined; the malpractice payments were not calculated by using the proper medicare formula; and the other programs were not related to patient care services. The record on which the findings of the PRRB were based, which record we must review to determine whether the Board's action was based on substantial evidence, include the trial transcript, Judge Wekselman's ruling, the exhibits and deposition testimony from the trial, a report from plaintiff's expert and other hospital records.

III. Plaintiff's Arguments

In support of summary judgment, plaintiff advances several arguments to support the position that the conversion costs should be reimbursed by Medicare. It argues that *stare decisis* and collateral estoppel require that this court apply the ruling of Judge Wekselman to this action. It argues that the PRRB misapplied the Medicare regulations by presuming that the parties were related in spite of evidence to the contrary. It argues that

the Board's ruling is not supported by substantial evidence. Finally, plaintiff argues that the characterization of the conversion as a stock transaction was arbitrary and without evidentiary support.

A. Stare Decisis and Collateral Estoppel

Monsour Medical Center prevailed in state court. Judge Wekselman ruled that the Monsours, although able to assert influence over the actions of the hospital board after the conversion, did not have the degree of influence required by the Medicare regulations to "control" the reconstituted Foundation. As Judge Wekselman ruled:

> The Court finds as a fact from the evidence that, subsequent to the conversion, control of the Foundation was in the Foundation Board and control of the hospital was in the hospital Board and that such control remains. Dr. William Monsour (board chairman) is undoubtedly influential, but his influence is based upon his powers of persuasion and his superior knowledge of the operation of the Foundation and of the hospital. . . . Neither Dr. William Monsour nor any other Monsour had the power significantly to influence the activities of the Foundation and hospital subsequent to the conversion or to impose his or their will on the respective Board of Directors.

Trial Tr. at 2668. Plaintiff urges that this court apply the finding here.

We note that the evidence presented to the PRRB and now to this court is indistinguishable from the evidence presented to Judge Wekselman. We also note that, in the interest of federal-state comity, uniformity of interpretation and *stare decisis*, we are tempted to apply the state court findings without further review. However, blithe application of the state court ruling would violate our limited jurisdiction in Medicare reimbursement cases, as crafted by Congress. According to 42 U.S.C. § 1395oo(f)(1), a district court can set aside PRRB rulings if the

findings and conclusions are not supported by substantial evidence. 5 U.S.C. § 706(2)(A)(E). This standard requires our thorough review of the evidence upon which the ruling was based. To apply Judge Wekselman's findings without further review would defy our duty as enunciated by the Social Security Act.

Plaintiff also argues that the state court ruling can be applied under the doctrine of offensive collateral estoppel. Under that doctrine, once an issue is actually determined by a court of competent jurisdiction, the determination is conclusive in later suits based on a different cause of action involving a party to the prior litigation. *Montana v. United States*, 440 U.S. 147 (1979). Collateral estoppel requires that the party against whom the doctrine is asserted (a) was a party or in privity with a party to the prior adjudication and (b) had a full and fair opportunity to litigate the issue in a prior action. *Kremer v. Chemical Construction Corp*. 456 U.S. 461, 480 (1982). We find that Medicare was neither a party nor in privity with Blue Cross in the state court litigation. Although the interests of Blue Cross and Medicare may have been similar, there is no evidence of record that Medicare directed or participated in the prior adjudication of the conversion issue. Also, plaintiff has not demonstrated that Medicare had a full and fair opportunity to litigate the issue in the prior action. Serious questions remain concerning whether Medicare could have participated in the state court hearing without exhausting federal procedures under the Social Security Act. *See*, e.g., 42 U.S.C. §§ 1395ff, 1395nn and 1395oo. We decline to apply the ruling of Judge Wekselman under the doctrines of *stare decisis* or collateral estoppel.

B. Substantial Evidence

Plaintiff next argues the ruling of the PRRB that the parties to the conversion of the hospital were related is not supported by substantial evidence. To resolve this argument, we have reviewed approximately 6,000 pages of trial testimony, depositions, and exhibits, which is the evidence reviewed by the PRRB. Included in the record are the findings and conclusions of Judge Wekselman. Thus, we may consider the cogent findings and reasoning of an able and respected state court jurist.

The issue faced by Judge Wekselman and the issue at bar are distinct. In state court, Blue Cross had to prove by a preponderance of the evidence that the transaction between the Monsour brothers and the reconstituted Monsour Medical Foundation involved "related" parties, as that term is defined in the Medicare regulations. In this court, the Center must show the ruling of the PRRB that the parties to the hospital conversion were related is not supported by substantial evidence of record. As rehearsed, substantial evidence is somewhat less than a preponderance of evidence. *Dobrowolsky v. Califano*, 606 F.2d 403, 406 (3d Cir. 1979). After reviewing the evidence, we find that Judge Wekselman's conclusions are persuasive. For purposes of the instant case, we agree with the following findings of fact and conclusions of law in *Blue Cross of Western Pennsylvania v. Monsour Medical Center*, No. GD-82-4968 (Alleg. Co. 1983):

> The evidence is clear that from the time of the conversion many officials of Blue Cross were suspicious of its bona fides. People concerned with the audit function of Blue Cross, both in its private capacity and as fiscal intermediary for Medicare, suspected that Dr. William Monsour was in effective control of its predecessor proprietary hospital. Jackson Lynch (of Blue Cross) in his overall supervisory capacity kept asking those in the auditing department to bring in facts upon which he could base a conclusion. No such facts were, however, forthcoming. Mr. Marinac (a Blue Cross auditor) continued his activities until such time as a complaint of harassment was made to Lynch. Lynch then instructed Marinac to discontinue the special audit.
>
> During the course of that special audit, Marinac followed every lead that he came upon. For example, he heard rumors that the brothers Monsour were being favored by admissions to their individual services from the emergency room of the hospital. He checked that out and found that no such favoritism existed. Many more examples exist of the matters which were looked into by various Blue Cross officials, but the long and short of it is that they could turn up

nothing which would enable them to come to a conclusion that actual control resided in the Monsours. . . .

Dr. William Monsour's deposition indicates that he did not believe himself to be in control of the voluntary hospital. He conceded that he made many suggestions which were followed by both the Foundation Board and the hospital Board. He attributed that to his encyclopedic knowledge of the operations and his expertise which was relied upon by what he considered to be the governing bodies in reaching decisions concerning the operations of the Foundation and the medical center. . . .

Blue Cross sought to establish that Dr. William Monsour was giving orders with respect to the payment of the second mortgage. The testimony does not support that contention. The testimony indicates instead that Dr. William Monsour from time to time made requests of responsible hospital officials that second mortgage payments be made. Despite those requests, the payments were skipped from time to time and eventually went into serious arrearage. . . .

This Court finds as a fact from the evidence that subsequent to the conversion, control of the Foundation was in the Foundation Board and control of the hospital was in the hospital Board and that such control remains.

Dr. William Monsour is undoubtedly influential, but his influence is based upon his powers of persuasion and his superior knowledge of the operation of the Foundation and of the hospital. It was never intended that control of the hospital continue in the Monsours subsequent to the conversion nor has such control continued in fact. Neither Dr. William Monsour nor any other Monsour had the power significantly to influence the activities of the Foundation and hospital subsequent to the conversion or to impose his or their will on the respective Boards of Directors. What was intended to be done was actually done both in law and in fact. Trial Tr. at 2656-69.

Defendant argues that Judge Wekselman considered whether the Monsours had actual control of the Center, not whether they had significant influence over the policies or actions of the facility. According to 42 C.F.R. § 405.427(b)(3), "control" exists "where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution." Reviewing the evidence of record, we find no support for the argument that Dr. William Monsour or any other Monsour singularly or collectively had the power "significantly to influence or direct the actions or policies" of the Monsour Medical Center. The record establishes the opposite. The hospital's bankruptcy petition in 1980 was filed over the objections of William Monsour. Trial Tr. at 1450. An executive vice president of the hospital was retained even though Howard Monsour urged the Board that he be dismissed for incompetence. Trial Tr. at 1884. Foundation funding for a project favored by William Monsour was reduced by more than one-half over his objections. Trial Tr. at 1047. And William Monsour was forced by the board of the Foundation to resign as chairman. Trial Tr. at 2326. Similar findings were made by Judge Wekselman, which establish that the Monsours had neither actual control nor significant influence over the Center.

We agree with plaintiff that the PRRB based its ruling that the transaction occurred between related parties on suspicion or reaction. The Board cited a 1974 plan of the Foundation (then controlled by the Monsours) to purchase the hospital and set up its own board of directors. The Board assumed that the new trustees of the Foundation "were acting as surrogates of the Family to implement the final stages of a corporate long-term plan which had been adopted by the Foundation in a prior period when it was controlled by the Monsour family. . . . There is no question that the Family, the Foundation, and the (Center) were related when the entire transaction was specifically planned. The fact that the transaction was executed almost precisely as

planned demonstrates the continuation of substantial control in fact." Tr. at 28. The PRRB's rationale begs the issue, *i.e.*, whether the Monsours continued to control the Center *after* the sale. The substantial evidence of record does not support the finding that the sale of the Monsour Medical Center was transacted between related parties.

As an alternative basis for denying reimbursement for the conversion costs, the PRRB found that the transition from a for-profit hospital to a non-profit hospital was accomplished though a sale of stock, not a sale of assets. As a result, the PRRB refused to recognize a stepped-up basis in the Center's depreciable assets and held that interest expenses in the transaction were not reimbursable because "the purchase of Family stock is not related to patient care." Tr. at 29. The decision states: "The Board finds that there is nothing in the record to show that a sale or transfer of land or depreciable assets ever occurred." Tr. at 29. There is "nothing in the record" because the stock-asset issue was specifically removed from the dispute by stipulation of the parties. Tr. at 717-18. The issue was not briefed or argued. We hold that there is no substantial evidence to support the finding of the PRRB that the transaction was a sale of stock because evidence was not presented to the Board on the issue.

IV. Snack Bar Expenses

The Center operates a 965-square-foot snack bar on the first floor of the hospital. Although primarily for hospital employees, it is patronized by patients and hospital visitors without restriction. Approximately 250 square feet of the snack bar is alloted to a gift shop that sells newspapers, magazines, candy and other gift shop items. (The Center provides a separate employee cafeteria.) The snack bar was operated independently of the hospital's dietary department.

After a 1980 audit, Blue Cross reclassified $349,285 from the dietary department cost center to the nonreimbursable snack bar cost center and refused to provide reimbursement for any unrecovered snack bar costs relating to employee meals for the years 1977 through 1980. Plaintiff states that this action cost the hospital approximately $318,000.

Plaintiff argues that a portion of the snack bar costs are reimbursable as reasonable and necessary expenses because employees ate meals at the snack bar when the cafeteria was closed. To establish the percentage of unrecovered snack bar costs attributable to employee meals for 1977 through 1980, the hospital cited studies conducted in 1981 which showed that between 65.2 and 67 percent of all snack bar costs were attributable to employee meals. Tr. at 2184-85.

The record simply does not establish with the required degree of accuracy the snack bar costs attributable to employee meals during the years in question. As defendant points out, 42 C.F.R. § 405.406 requires that "providers maintain sufficient financial records and statistical data for proper determinations of costs payable under the (Medicare) program." As to the snack bar operation, we can apply Judge Wekselman's opinion that "[t]he hospital's record keeping might most charitably be characterized as chaotic." Trial Tr. at 2655. Apparently, little or no attention was given to separating general snack bar expenses from employee-related expenses. As a result, documentation that could be used to compute an accurate allocation is not available. The PRRB adopted the Blue Cross allocation of dietary department costs to the snack bar. We find that the decision is supported by substantial evidence of record.

V. Other Program Expenses

Plaintiff next challenges the Blue Cross treatment of expenses associated with three outpatient programs offered by the Center — the Drug & Alcohol Program, the Driving While Intoxicated Program and the Women, Infants & Children Program. At issue is the Blue Cross revised 1979 cost-finding approach to these programs. After adjustments and calcuations based on plaintiff's billings to the grant agencies funding these programs and the actual program expenses recorded, Blue Cross determined that these programs received significant services from the hospital. Blue Cross then made adjustments in Medicare reimbursements to the hospital for 1979. Plaintiff alleges

that the indirect hospital costs associated with the funded programs were *de minimis* and outside grant funding for each program already included substantially all identifiable indirect costs.

Again, we must determine whether the Secretary's decision is supported by substantial evidence. *Home Health Services v. Schweiker, supra*. The PRRB decision states:

> [T]he three funded programs involved activities not related to patient care services and their costs must be classified in a nonallowable cost center. . . . The Board concludes that there is substantial evidence that the funded programs received services from the (Center). Therefore, the costs associated with the (Center's) general service cost centers must be allocated to the funded programs' nonallowable cost center.

Tr. at 28. The decision is based on the disparity between the programs' costs as billed to grant agencies and the actual program expenses as recorded. Tr. at 951, 957-59. The decision also is based on the use of Center employees to work in the programs. Tr. at 881-82. Although we do not find this evidence to be dispositive, we hold that there is substantial evidence to support the Secretary's decision.

VI. Malpractice Insurance

The fourth and final reduction is the $80,000 adjustment for malpractice insurance in 1980 and 1981. Plaintiff challenges that reduction, under 42 C.F.R. § 405.452(a)(1)(ii), as procedurally infirm and substantively invalid because it does not tie reimbursement for malpractice insurance to the actual use of the hospital by Medicare patients. The Medicare regulation has been declared invalid by the Court of Appeals in *Abingdon Memorial Hospital v. Heckler*, 750 F.2d 242, 242 (3d Cir. 1985), *cert. denied*, ____ U.S. ____, 54 U.S.L.W. 3227 (October 3, 1985). According to the teachings of the Court of Appeals, we shall remand this issue to the PRRB with instructions to award plaintiff remibursement for malpractice insurance costs incurred during fiscal years 1980 and 1981.

VII. Summary

When a decision of the PRRB is adopted by the Secretary and appealed to a district court, the court must determine whether the findings and conclusions are supported by substantial evidence. Because our task involves reviewing the evidence presented to the PRRB, we decline to apply the findings and conclusions of Judge Wekselman in a related state court case. After reviewing the evidence of record, we hold that the findings of the PRRB regarding costs associated with the conversion of the Monsour Medical Center from a for-profit institution to a non-profit institution as well as the malpractice insurance costs are not supported by substantial evidence. We shall grant judgment to plaintiff and remand these two issues to the PRRB with instructions to properly reimburse plaintiff for these costs. We further find that the findings of the PRRB regarding the costs associated with the snack bar at the Center and the three outpatient programs are supported by substantial evidence. As to these two issues, summary judgment shall be granted for defendant.

A written order will follow.

DATED: December 30, 1985

/s/ DONALD E. ZIEGLER
Donald E. Ziegler
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

MONSOUR MEDICAL CENTER,
Plaintiff,

vs. **Civil Action 84-1938**

MARGARET M. HECKLER,
Secretary of Health
and Human Services,
Defendant.

ORDER OF COURT

AND NOW, this 30th day of December 1985,

IT IS ORDERED that plaintiff's motion for summary judgment as to the costs associated with the hospital conversion and malpractice insurance be and hereby is granted.

IT IS FURTHER ORDERED that defendant's motion for summary judgment as to the costs associated with plaintiff's snack bar and three outpatient programs be and hereby is granted;

IT IS FURTHER ORDERED that the case be and hereby is remanded to the Provider Reimbursement Review Board for reimbursement of two items consistent with the accompanying opinion.

/s/ DONALD E. ZIEGLER
Donald E. Ziegler
United States District Judge

cc: Counsel of record.

APPENDIX C

[1984-2 Transfer Binder]
Medicare & Medicaid Guide (CCH) ¶34,138

Provider Reimbursement Review Board Hearing Decision

84-D133

Provider—Monsour Medical Center, Jeannette, Pennsylvania

Provider No. 39-0103

vs

Intermediary—Blue Cross and Blue Shield Association/ Blue Cross of Western Pennsylvania

Date of Hearing—October 6 and 7, 1983

Cost Reporting Periods Ending—June 30, 1977, 1978, 1979, 1980 and 1981

Case No.—80-24

June 14, 1984

ISSUES:

1. Whether the Intermediary's specific allocation of dietary department costs to the Provider's snack bar was correct? (1977, 1978, 1979 and 1980 cost years)
2. Whether the Intermediary's adjustments offsetting the Provider's inpatient consultation income against the Provider's general operating costs were correct? (1977, 1978, 1979, 1980 and 1981 cost years)

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3. Whether the Intermediary's disallowances of the Provider's malpractice insurance costs under the malpractice rule (42 CFR 405.452(b)(1)(ii)) were correct? (1980 and 1981 cost years—Heard on the Record)
4. Whether the Intermediary's adjustments reducing the Provider's costs by the amount of contributions to and interest income earned by Monsour Medical Foundation were correct? (1977, 1978, 1979 and 1980 cost years)
5. Whether the Intermediary was correct in determining the costs of various funded programs operated by the Provider by establishing a nonallowable cost center instead of accounting for the costs of such programs through the use of a revenue offset? (1979 cost year)
6. Whether the Intermediary's disallowance of the Provider's second mortgage interest and associated "stepped-up" depreciation expense was correct? (1977, 1978, 1979, 1980 and 1981 cost years)

SUMMARY OF FACTS:

The Provider is a 233-bed, acute-care hospital. The Intermediary audited the Provider's cost reports for the fiscal years ending June 30, 1977, 1978, 1979, 1980 and 1981 and issued Notices of Program Reimbursement (NPR). The Provider took exception to the Intermediary's adjustments pertaining to the above issues and filed requests for hearings with the Provider Reimbursement Review Board (Board) pursuant to 42 CFR 405.1835ff and has met the jurisdictional requirements therein.

Issue 1—Snack Bar:

The Provider operates a snack bar which is open to the public and patronized by employees, patients and visitors. In addition, it also maintains an employee cafeteria that is open at lunch time on weekdays and alternating holidays. During the cost reporting periods in contention, the Provider's dietary department was operated by an outside contractor whose services included the operation of the cafeteria and ordering, storing and assembling the food which was transferred to and served by the snack bar. The Provider utilized its own employees to staff the snack bar, which is a joint operation with the Provider's gift shop.

The Provider filed its cost reports for the years in contention claiming the snack bar as a nonreimbursable cost center. During the audit of the Provider's 1980 cost report, the Intermediary discovered that certain costs of the snack bar were reported in the dietary/cafeteria cost centers. The Intermediary made an adjustment to reclassify those 1980 dietary costs to the snack bar and reopened the 1977 through 1979 cost reports to make similar adjustments. The Intermediary relied upon data furnished by the outside contractor in making the adjustments inasmuch as the Provider was unable to produce verifiable documentation.

The Provider appealed the Intermediary's reclassification adjustments. Also, it took exception to the Intermediary's failure to recognize the unrecovered costs associated with employee meals served by the snack bar as allowable employee fringe benefit costs. The impact of these adjustments on Medicare reimbursement is approximately $318,000.

Provider's Contentions:

The Provider contends that the reclassification adjustments are erroneous because the amounts transferred to the snack bar are excessive, and the document of the outside contractor relied upon is unsuppportable and was misunderstood by the Intermediary. It argues that the outside contractor's report tranfers excessive dietary labor costs and raw food costs when compared to the total costs of its dietary/cafeteria departments. In support of its position, the Provider cites a study it developed showing that an equivalent snack bar meal exceeded $10 per meal whereas an inpatient meal costs only $3.69. Since the outside contractor was not responsible for the snack bar, it was in that company's best interest to shift costs excessively to the snack bar to make its operation of the dietary department appear more cost effective.

The Provider also contends that the Intermediary's adjustments fail to consider snack bar costs associated with employee meals, which are reimbursable under Medicare policy. The Provider performed a utilization study in 1981 to determine the unrecovered employee meal costs for the snack bar which the Intermediary accepted for its 1981 cost reporting period. The

Provider believes the Intermediary should have utilized the 1981 data and rationale to estimate the unrecovered employee meal costs for the prior cost reporting periods. It argues that the Intermediary's insistence on a contemporaneous study is inconsistent since the Intermediary utilized 1980 data in making its retroactive adjustments for the 1977 through 1979 cost reports. The Provider cites various decisions rendered by the Board and the Administrator of the Health Care Financing Administration (HCFA) which relied upon after-the-fact estimates in determining Medicare reimbursement.

Intermediary's Contentions:

The Intermediary contends that its determination was based upon the proper application of 42 CFR 405.451, 42 CFR 405.453 and Sections 2102.3 and 2328 of the Provider Reimbursement Manual, Part I (HIM 15-1). These citations establish the basic reimbursement tenets that only the necessary and proper reasonable costs incurred in the provision of patient care services are reimbursable under the Medicare program. Such costs must be supported by adequate and auditable documentation and must be determined in accordance with the cost finding procedures which provide for the full costs of the operation.

The Intermediary asserts that its determination was based on the best records available in the ordinary course of business. The Provider has consistently failed to produce acceptable documentation which would permit a determination of the actual unrecovered costs of employee meals served by the snack bar during the periods in contention. The Intermediary argues that it is the Provider's responsibility to furnish adequate documentation to support its costs, and it was the breach of this duty which forced the Intermediary to rely upon the data of the outside contractor.

In response to the Provider's request that the Board utilize the data and methodology developed in the study accepted for the 1981 cost reporting period, the Intermediary states that it is not possible to apply the 1981 approach retroactively without some measure of proof from the Provider's records that the earlier cost reporting periods are comparable and that the 1981 ex-

perience is representative of activities in those years. The Intermediary points out that activities in the cafeteria and snack bar were in a constant state of flux during the 4 years under appeal so that it expects that the 1981 statistics do not reasonably or accurately represent activity in those prior years. Additionally, the revenue and cost data represent a combination of both the snack bar and gift shop operations. Thus, the amount in controversy includes the unrecovered costs for gift shop items and there is no meaningful way to isolate the unrecovered costs of employee meals for 1977 to 1980. The determination of unrecovered costs of employee meals in 1981 was made after the transfer of both cost and revenue into the cafeteria cost center.

Since the snack bar and cafeteria were separate operations during the 1977 to 1980 periods, the Intermediary believes there is no practical way to apply the 1981 methodology to those periods. In summary, it is the Intermediary position that the lack of documentation and consistency in both the snack bar and cafeteria operations and in the Provider's accounting support its adjustments and treatment of the snack bar as a nonallowable cost center.

Issue 2—Inpatient Consultation Income:

During the cost reporting periods in dispute, the Provider retained medical specialists to perform consultations for the hospital's attending physicians and hospital inpatients. Generally, these physicians were paid a salary for their professional services and the fees received for their services were assigned to the hospital. The Intermediary made several types of adjustments for the periods in dispute to offset the physicians' income against both the outpatient and inpatient areas. Additional Provider documentation and discussions thereof between the parties both prior to and subsequent to the hearing enabled the Intermediary to reverse a number of its initial adjustments and to narrow the issue and the amounts in contention. Inpatient consultation income relating to physicians who do not have compensation arrangements with the Provider remains the only item in dispute.

It is the Intermediary's position that the Provider collected fees levied on hospital inpatients which represent a charge for

the privilege of permitting a consultation on the hospital's premises. The Intermediary determined that this income represented a recovery of costs incurred by the hospital and should be offset against the Provider's routine care costs. The estimated impact of these adjustments is approximately $47,000 for all years in contention.

Provider's Contentions:

The Provider states that it did impose a $4.00 clinic charge on ambulatory care clinic outpatients to help defray the administrative expense of this nonreimbursable unit. However, it contends that the Intermediary erroneously assumed that similar inpatient hospital charges were imposed and recorded as inpatient consulting income whenever a specialist physician from the ambulatory care clinic saw an inpatient in the hospital. The Provider asserts that it did not impose any such charge on hospital inpatients and that the unrebutted evidence presented at the hearing supports this fact.

In response to the Intermediary's post-hearing submission, the Provider points out that the Intermediary admits that it was unable to produce bills or other documentation of the purported $4.00 charge and had failed to uncover any evidence of such charges. Thus, the Intermediary's assertion is based on speculation and is entirely unsupported.

The Provider further argues that even if such a charge were levied, there is no authority under the Medicare program for offsetting patient revenue against otherwise allowable operating cost as a credit. The provisions of Section 2302.5 of HIM 15-1, which the Intermediary cites, pertains to an income item which serves to reduce costs and would not apply to patient revenues. The Provider further asserts that Section 2108.10 of HIM 15-1 is also inapplicable because this provision applies to medical services rendered by a physician to nonprovider patients and not to hospital inpatients. The Intermediary's reliance on these manual provisions as support for its adjustments misconstrues their intended application.

Intermediary's Contentions:

The Intermediary contends that its adjustments are consis-

tent with the cost finding requirements of 42 CFR 405.453 and the income credit offsets applied under Section 2302.5 of HIM 15-1. The Intermediary believes the inpatient consultation income is similar to other forms of revenues collected by providers through nonpatient-related activities. It likens the inpatient consultation income to the sale of scrap silver by a provider's X-ray department. The Provider claims the cost of purchasing X-ray film in its cost report and Medicare reimburses a share of the cost through the apportionment process. Since the Provider is reimbursed for costs incurred in the patient care area, a recovery of such costs through a nonpatient-related activity necessitates an income offset as a credit against the associated expenses incurred. In the instant case, the Intermediary states that the credits described in Section 2302.5 of HIM 15-1 would apply and it is proper to offset the inpatient consultation income against the Provider's routine costs.

The Intermediary bases its adjustments on oral explanations furnished by the Provider's Administrator and Chief Financial Officer that such a fee was charged to patients for use of hospital facilities while being treated or examined by private physicians. Based upon this explanation and the documentation and testimony presented by the Provider, the Intermediary concludes that the Provider generated inpatient income from physicians' private billing and that a portion of the income is deductible. The Intermediary also cites the provisions of Section 2108.10 of HIM 15-1 as further support for its income offset adjustments.

Issue 3—Malpractice Insurance:

The Provider included malpractice insurance premium expenses as an expense in its administrative and general (A & G) cost center and sought reimbursement on its 1980 and 1981 cost reports based on the Medicare utilization rates in effect for the two cost reporting periods. The Intermediary excluded these expenses from the A & G cost center and reimbursed the Provider's malpractice insurance costs in accordance with the provisions of 42 CFR 405.452(b)(1)(ii). The Intermediary's adjustments reduced Medicare reimbursement by approximately $80,000.

Provider's Contentions:

The Provider contends that the malpractice regulation, 42 CFR 405.452(b)(2)(ii) is procedurally and substantially invalid under the Administrative Procedure Act and the Medicare Act. The regulation violates the Administrative Procedure Act because it was not promulgated in accordance with the mandatory notice and comment procedures and is arbitrary, capricious and an abuse of discretion. The regulation also violates the provisions of the Medicare Act because it fails to reimburse a provider's reasonable and actual costs, shifts the costs of Medicare patients to non-Medicare patients and was promulgated without regard to the reimbursement principles developed by other third-party payors.

Intermediary's Contentions:

The Intermediary contends that its adjustments were correctly made within the malpractice apportionment requirements of 42 CFR 405.452(b)(1)(ii). It asserts that the Board has no authority to inquire into the wisdom or propriety of any Medicare regulations and substitute its own judgment for that of the Secretary of the Department of Health and Human Services. Thus, the Board must limit its authority to whether the Intermediary correctly applied the regulation and not whether it is good policy.

Issue 4—Foundation Contributions/Income:

The Intermediary made various adjustments to the Provider's cost reports for the 1977 through 1980 reporting periods for contributions made to and investment income earned by the Monsour Medical Foundation (Foundation). The adjustments were based on the Intermediary's conclusion that the Foundation and the Provider were related organizations and must be collapsed and considered a single entity.

One element of the Intermediary's adjustments pertains to donations made to the Foundation in the forms of: hospital vendor contributions, contributions received from the Provider's hospital-based physicians, and other miscellaneous contributions. The Intermediary relied upon the application of 42 CFR 405.427, 405.425 and Section 806 of HIM 15-1 in making its ad-

justments. The amount of Medicare reimbursement in controversy for the contribution element of this issue is approximately $48,000. The Board denied jurisdiction for contributions which were self-disallowed by the Provider and, therefore, are not a part of the issue in this case.

The second element of the Intermediary's adjustments relates to the offset of the Foundation's investment income against the Provider's interest expense. The Intermediary's offset adjustments were based on the application of 42 CFR 405.427, 405.419 and Section 202.2 of HIM 15-1. The impact on Medicare reimbursement for the investment income offset is approximately $32,000.

Provider's Contentions:

The Provider contends that the related party rule of 42 CFR 405.427 relates to the costs of services, facilities and supplies furnished by a related entity and has nothing to do with donations or the offset of investment income. It further asserts that 42 CFR 405.427 does not justify the Intermediary's basic premise that the separate corporate identities of the Foundation and the Provider should be ignored so they may be considered as a single entity. The Provider cites various court decisions wherein the courts ruled that the corporate existence of each entity must be recognized even where the corporations were related under Medicare regulations. In further support of its position, the Provider refers to PRRB Decision 83-D23, *Pioneer Hospital v. The Travelers Insurance Company*, which dealt with the question of whether the financial resources of all entities related to the provider should be considered in determining the necessity of a provider's borrowing pursuant to 42 CFR 405.419(b). In that decision, the Board rejected the Intermediary's claim that the entities should be collapsed and stated that only the provider's financial circumstances may be considered in determining the necessity of the borrowing.

In rebuttal to the Intermediary's application of Section 806 of HIM 15-1, the Provider argues that this provision is not applicable because the contributions were made to the Foundation and not to the Provider. As to the donations from physicians

practicing at the hospital, the Provider further contends that Section 806 of HIM 15-1 cannot be applied because the physicians made voluntary contribution and were not contractually obliged to make a donation. Moreover, the physicians' contributions qualify as an exception to Section 806 since they were subject to a comparable solicitation effort as that found in community-wide fundraising campaigns.

The Provider asserts that the Intermediary's disallowance of miscellaneous contributions because of its inability to identify the source of these funds is also unfounded. It argues that Section 806 does not extend to donations from nonvendors or to miscellaneous rebates and that the requirement for accurate records under the Medicare program does not extend to nonproviders such as the Foundation.

Intermediary's Contentions:

The Intermediary contends that it is necessary to consider the corporate entities of the Provider and the Foundation as one in order to accomplish the Medicare objective of reimbursing the Provider for the reasonable cost of providing care to Medicare beneficiaries because portions of certain transactions were split between the two related entities. The Provider, as the cost reporting entity, claimed costs of: money (interest), patient care related supplies and services, operation of plant, administration, and professional services. Looking at the cost report of the Provider alone, its costs are overstated because: (1) The Foundation receives revenues and earns income that affects the cash position of the hospital, and (2) cost recoveries which would normally accrue to the Provider are diverted into the Foundation. Also, the Foundation runs the Provider, it is not merely a separate development or fundraising entity created only for that limited purpose. Therefore, it is appropriate to combine the two for reimbursement purposes.

The Intermediary asserts that its adjustments are consistent with the application of pertinent Medicare policy. The treatment of the vendor rebates and physicians' contributions are specifically addressed in 42 CFR 405.425 and Section 806 of HIM 15-1. The Intermediary observes that the physicians are vendors of

services to the Provider and their status could be affected by their willingness to contribute to the Foundation. It also asserts that documents demonstrate that the physicians' contributions were related to their compensation and to their free use of office space within the Provider's facility for their private medical practice.

The Intermediary based its income offset and adjustment on the provision 42 CFR 405.419(b)(2)(iii). That section recognizes that interest expense may be unnecessary when the Provider has assets to utilize for working capital or other purposes but chooses to make investments and borrow at the same time to meet its needs.

The Foundation collects the income from the Provider's telephones, televisions, gift shop and other activities. This income would ordinarily be available to the Provider for use since it relates specifically to the Provider's operations. By keeping this revenue in the Foundation, it denies the Provider cash and forces it to borrow to meet working capital needs. Here, the Foundation retains and invests income which should go directly to the Provider. For that reason, an interest offset is appropriate under these circumstances.

The Intermediary notes that the issue is further compounded by a documentation problem. The Foundation's income includes income generated from hospital operations as well as income generated by invested donations. Since the Provider was unable to identify how much of its income related to each source, the amount in controversy reflects all Foundation income.

Issue 5—Funded Programs:

The Provider operated three grant programs: Drug and Alcohol Program (D & A); Driving While Intoxicated Program (DWI); and Women, Infants and Children Program (WIC). The Provider filed its cost report for the 1979 cost year reporting the funded programs as allowable cost centers and made a revenue offset for each of the programs, as it had done in prior years. The Intermediary required setting up these programs as a nonallowable cost center to eliminate their total costs through the

stepdown, cost finding process. The Intermediary made adjustments restoring the revenue offsets and established a nonallowable cost center for the three funded programs. The estimated impact on Medicare reimbursement is $48,000.

Provider's Contentions:

The Provider contends that the establishment of the three funded programs as a nonallowable cost center and allocation of indirect costs through the stepdown process results in a clear overallocation of cost contrary to Medicare law and regulations. It argues that the budgeted amounts for each program already included all direct and indirect costs under the respective grant agreements. All three programs operated with their own personnel and facilities. Any Provider costs associated with the administration of these programs were extremely minimal and were budgeted for and reimbursable under the grant agreements. The allocation of additional hospital cost through the cost finding process improperly and illegally duplicates the indirect costs of these programs. Additionally, the stepdown, cost finding process results in an overallocation of Provider costs in light of the manner of operation, location and limited scope and hours of services provided by the funded programs.

The Provider argues that the proper method of accounting for the costs of the funded programs is through the application of revenue offsets as required under Medicare principles. The Provider states that the provisions of 42 CFR 405.423(b)(2) and Section 602.2 of HIM 15-1 both require the offest of revenue for the type of restricted grants associated with these funded programs. Thus, the Intermediary does not have the discretion to use a nonallowable cost center. This center is inconsistent with the Intermediary's treatment of these programs in prior cost reporting periods.

The Provider further argues that Section 2328.D of HIM 15-1 permits a revenue offset for nonallowable costs without the establishment of a nonallowable cost center where costs are insignificant. Since the costs of each funded program are not significant individually, the Provider asserts that each program meets the standards of Section 2328.D. The Provider believes

that such treatment is particularly applicable for the Drug and Alcohol Program for the 1979 cost reporting period. Accordingly, the Intermediary's aggregation of the three funded programs should not be used to justify its rejection of the revenue offset authorized by Section 2328.D. The Provider believes that an alternative approach would permit the use of the revenue offset method under Section 2328.D for the D & A Program and the establishment of a nonallowable cost center for only the DWI and WIC Programs.

Should the establishment of nonallowable cost centers be deemed the appropriate treatment of the funded program, then the Provider recommends that all indirect costs discretely costed to the funded programs should be removed and included with the Provider's overhead cost centers for allocation purposes through the cost finding process. The Provider believes this would partially correct the overallocation problem created by the Intermediary's erroneous determination.

Intermediary's Contentions:

The Intermediary contends that proper cost finding under the provisions of 42 CFR 405.453(b)(1) and Sections 2302.ff and 2328ff of HIM 15-1 require the establishment of the three funded programs as a nonallowable cost center. The accurate determination of costs associated with these programs would also require their absorption of the Provider's indirect cost through the stepdown, cost finding process.

The Intermediary argues that the lack of records and documentation makes it impossible to determine whether costs are overallocated. The program locations and the number of personnel varied. Unless verifiable documentation can be presented to justify a modified form of cost finding using discrete costing or weighted statistics, as recommended by the Provider, it is the Intermediary's position that the only appropriate recourse is the cost finding methodology and the establishment of a nonallowable cost center.

The Intermediary contends that the grant offset provisions of 42 CFR 405.423 only pertain to reimbursable patient care related activities. Since the funded programs at issue are not as-

sociated with the Provider's patients, their costs are not related to the provision of patient care. Accordingly, the revenue offset provisions of 42 CFR 405.423 are not appropriate.

Issue 6—Interest/Depreciation Expense:

In May of 1975, the Provider changed from a forprofit to a not-forprofit corporation through a series of transactions involving Monsour Hospital and Clinic, Inc. (MHC), Monsour Medical Foundation (Foundation) and Monsour Medical Center (MMC).

MHC is the predecessor of the current Provider (MMC) and participated in the Medicare program prior to the conversion.

MHC was founded in 1952 as a forprofit corporation by Drs. Howard, Roy and Robert Monsour (brothers) and their parents. Dr. William Monsour (a fourth brother) became involved at a later date. Together, the following members of the Monsour family owned all of the stock of MHC at the time of the change:

Shareholder	Shares
Mrs. Eva Monsour	6
Robert G. Monsour, M.D.	61
Roy C. Monsour, M.D.	61
Howard P. Monsour, M.D.	61
William J. Monsour, M.D.	61
TOTAL	250

The Foundation was organized in 1966 as a not-for-profit corporation by the following incorporators:

William J. Monsour, M.D.
Roy C. Monsour, M.D.
Robert G. Monsour, M.D.
Mrs. Eva Monsour
Omar B. Ayoub, M.D. (Cousin)

MMC (the current Provider) is a not-forprofit corporation which was established as a result of transactions occurring in May 1975.

The change evolved from transactions involving MHC stock which were proposed in various Provider documents as follows:

The members of the Monsour family (Family) would sell certain MHC shares to the Foundation for $500,000. MHC would purchase additional shares (but less than 50 percent of the total number outstanding) for $7,500,000. The Family would donate the remaining shares to the Foundation. The precise number of shares would be based on the book value as of the end of the month preceding the sale or gift. The book value would reflect the revaluation of the plant and equipment in the appraisal prepared by J. Walton Barson, M.A.I.

The purchase price of the shares acquired by MHC would be payable in monthly installments over a period of 20 years with interest at 6 percent for the first 5 years and thereafter at the prime rate in effect from time to time at a designated bank. During the first 5 years, there would be even monthly payments, including principal and interest, of $53,732.35.

MHC would retire the treasury stock purchased from the Family. The Foundation would remain as the sole stockholder of 100 percent of the outstanding stock of MHC. Immediately after the retirement of the stock by MHC, that corporation will be converted into a Pennsylvania nonprofit corporation.

The effect of these transactions would be that the Foundation would own MMC as a subsidiary.

The actual transactions were adopted by the trustees of the Foundation at a special meeting held on May 19, 1975 as follows:

1. Foundation to purchase 8.3 shares at $60,259 per share for a total of $500,000;
2. Family agreed to donate to the Foundation 117.24 shares at $60,259 per share for a total of $7,064,765;
3. Foundation would own 125.54 shares of the original 250 shares owned by the Family; and
4. The $60,259 per share value of the stock was based upon a 1974 appraisal of $18 million. The book value of land and depreciable real and personal property was shown on the MHC balance sheet as of June 30, 1974 at $3,568,524. Stockholders' equity at June 30, 1974 was $561,043 or $2,244 per share.

The Board of Directors of MHC also met on May 19, 1975, and acted on the following:

1. MMC to purchase 124.46 shares from the Family at $60,259 per share for a total of $7,500,000 with payment to be made with interest over a period of 20 years pursuant to a note; and
2. Adopted Articles of Conversion to a Pennsylvania Non Profit Organization form.

The Intermediary determined that the transactions were between related parties. Therefore, the Provider is not entitled to a stepped-up basis of depreciation for the buildings and equipment. Also, the interest expenses incurred on the note for the stock purchase are not allowable. The Intermediary's adjustments to depreciation and interest expenses claimed by the Provider reduces the amount of Medicare reimbursement by approximately $1,381,000.

Provider's Contentions:

The Provider contends that the Intermediary's disallowance of interest and depreciation expense is based on the erroneous conclusion that the transactions were between related parties and, therefore, not arm's length. The Provider argues that the identical issues were the subject of extensive litigation between the Provider and the Intermediary in its private business capacity in the Court of Common Pleas of Allegheny County, Pennsylvania, *Blue Cross of Western Pennsylvania v. Monsour Medical Center, No. GD-4968*. In that decision, the court concluded that the conversion was, in fact, an arm's-length transaction among unrelated parties.

The Provider asserts that the trial court's judgment is entitled to special weight because its decision considered almost 8 years of hospital operation subsequent to the conversion. Thus its decision was based on actual control rather than the potential ability to control. The Provider urges the Board to accept the findings and verdict of the trial court.

The Provider also contends that the Intermediary was initially consulted to determine whether the interest and depreciation expenses connected with the conversion would be considered reimbursable and whether the conversion should,

therefore, go forward. The Intermediary reviewed the proposals, made suggestions to ensure that its concerns with control and the arm's-length nature of the transaction would be satisfied. After certain changes were made, it approved the conversion. Based upon the Intermediary's prior assurances that the conversion transactions met the Medicare's criteria for reimbursement, the Provider implemented the conversion. Up until December 1981, it was reimbursed the interest and depreciation connected with the conversion.

Accordingly, the Provider contends that the Intermediary is estopped from reopening the cost reports and disallowing the interest and depreciation expenses. In support of this position, the Provider cites two court decisions; *Columbia Heights Nursing Home and Hospital, Inc., v. Weinberger*, 380 F. Supp. 1066 (M.D. La. 1974), and *Community Health Services of Crawford County, Inc., v. Califano*, F.2d, No. 82-5098 (3d Cir., January 19, 1983), wherein the Intermediary was estopped from recovering Medicare reimbursement where the Provider relied upon the prior approval or advice of the Intermediary.

In response to the Intermediary's contentions that relationship existed between MHC and the Foundation, the Provider argues that such a position is fundamentally mistaken because the Foundation is not a provider and did not acquire any of MHC's assets. Since the Provider (MMC) became the owner of the former provider's (MHC) assets and is the payor on the note to the Monsour family, it is the relationship between the Provider (MMC) and the Monsour family that must be examined.

The Provider asserts that the Monsour family and the Provider (MMC) are not related parties. As the sole corporate member of the Provider (MMC), the Foundation could control the Provider pursuant to Pennsylvania law. However, in order for the Monsour family to control the Provider (MMC), it is necessary to demonstrate that the family actually controlled or had the power to control the Foundation. Since the Monsour family constituted only 1/13 of the members and Board of Directors of the Foundation, this was not sufficient to constitute majority control.

As to the Intermediary's contention that the Monsour family appointed the members and directors of the Foundation and,

therefore, could in fact control the Foundation, the Provider states that although this argument may have some appeal in a commercial setting it is nonsense in the nonprofit setting generally and is not supported by the record in this case. The Provider argues that such relationship is not significant enough to constitute control, especially where the members serve as volunteers and without compensation. As with any nonprofit organization, the directors owed their fiduciary duty by law to the entity and not to any individual who might have sponsored their appointment initially.

As an alternative argument, the Provider argues that should it be determined that the conversion transactions were between related parties, the Provider should be reimbursed a portion of the interest costs at issue consistent with the Court's decision in *Northwest Hospital, Inc., v. Hospital Service Corporation*, 687 F.2d 985 (7th Cir. 1982). In that case, the Court allowed interest expense on a loan balance equal to the depreciated cost of the hospital's assets at the time of the sale (less any cash received in the transaction). The Provider asserts that the *Northwest Hospital* case involved a factual situation almost identical to the present case.

Intermediary's Contentions:

The Intermediary contends that the conversion transactions by which the Provider (MMC) acquired the assets of MHC were between related parties pursuant to the related organization principles of 42 CFR 405.427. Based on this finding, the Provider is not entitled to a stepped-up basis of depreciation under the provisions of 42 CFR 405.415(g) and the interest expense incurred on the loan resulting from the conversion is not allowable under 42 CFR 405.419ff.

In support of its position, the Intermediary asserts that it is necessary to review the history of the parties involved in the transactions and the chronology of events which led up to the conversion of the Provider from a for-profit to a not-for-profit corporation.

The Foundation was started with the Family as its incorporators and trustees. At the first meeting of the Foundation, the

stated purpose of the Foundation was to perpetuate the medical interest of the Family for the benefit of the community of the State of Pennsylvania and for the United States (see Intermediary Exhibit 506). At this early point, there can be no doubt that there was common control as between the Foundation and the Hospital.

By April of 1972, the Foundation had 10 trustees (see Exhibit 507) but still had its same five members. Since the members selected the trustees, it is clear that the Family was in absolute control of the Foundation and the Hospital. At an April 1972 meeting, the Foundation agreed to purchase the Hospital stock of any member of the Family who might die.

In January 1975, 3 more trustees were added, bringing the total to 13. This total included the same 10 trustees from 1972. The members were still the original group of five (the Monsour family). Since the members still elected the trustees, control between the Foundation and the Hospital remained solid. At the January 1975 meeting, the conversion was first approved. In May 1975 (Exhibit 312), the Foundation expanded the membership of the Foundation from 5 to 13.

To summarize, the Family owned the Monsour Hospital and Clinic. They established the Monsour Medical Foundation with the family as the Members. The members appointed the trustees. Between 1967 and 1975, the members appointed 13 trustees. It was these trustees (appointed by the Monsours) who agreed to purchase the stock owned by the Family.

The Regulation, 42 CFR 405.427(b)(3) looks at common control. As owners of the stock, they absolutely controlled MHC. As the members of the Foundation, the Family had the power to significantly influence any action of the Foundation. Therefore, the sale from the Family to the Foundation was a sale between parties related by common control. This is the point in time when relatedness must be determined.

In examining events subsequent to the conversion meeting, control by the Family was still evident. The Intermediary had first thought that the Family would step out of hospital operations and let the not-for-profit entity function as a new and independent corporation. However, the Foundation tightened its

hold on the new entity. The Foundation, as the sole member of MMC, would elect the Board of the Provider. The Foundation could disregard any action of the separate MMC Board. Another important fact is that an Executive Committee for the Foundation was created and Dr. William Monsour was its Chairman. This is not a ceremonial position. It is an important oversight position and demonstrated the presence of the Family in the continued operation of the Provider.

Thus, the Intermediary concludes:

1. The transfer of assets from MHC to the Foundation and then to MMC was not a *bona fide* sale. Therefore, the depreciation reimbursed to MMC is calculated on the basis of the assets in the hands of MHC. No increase should be recognized (42 CFR 405.415(g)(3); and
2. The interest paid by the Foundation to the Family was on a loan between related parties. The interest should be disallowed pursuant to 42 CFR 405.419(b)(3)(iii).

CITATION OF APPLICABLE LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. **Law—Title XVIII of the Social Security Act:**
   - a. Section 1861(b) —Inpatient Hospital Services
   - b. Section 1861(q) —Physicians' Services
   - c. Section 1861(v)(1)(A) —Reasonable Cost

2. **Regulations—42 CFR 405, Subpart D:**
   - a. Section 405.401 —Introduction
   - b. Section 405.402 —Cost Reimbursement; General
   - c. Section 405.406 —Financial Data and Reports
   - d. Section 405.415 —Depreciation: Allowance for Depreciation Based on Asset Costs
   - e. Section 405.419 —Interest Expense
   - f. Section 405.423 —Grants, Gifts, and Income from Endowments
   - g. Section 405.425 —Purchase Discounts and Allowances, and Refunds of Expenses
   - h. Section 405.427 —Cost to Related Organizations
   - i. Section 405.451 —Cost Related to Patient Care
   - j. Section 405.452 —Determination of Cost of Services to Beneficiaries
   - k. Section 405.452(b)(1)(ii) —Exception

l. Section 405.453 —Adequate Cost Data and Cost Finding

m. Section 405.480 —Determining Reimbursement for Services Performed by Hospital-Based Physicians

n. Section 405.482 —Program Payments for Physicians' Services to Hospitals and to Individual Patients

o. Section 405.483 —Physician Service under Part B

p. Section 405.486 —Effect of Physician's Assumption of Operating Costs

q. Section 405.1803 —Intermediary Determination and Notice of Amount of Program Reimbursement

r. Section 405.1835 —Board Hearing; Right to Board Hearing

s. Section 405.1867 —Sources of Board's Authority

t. Section 405.1869 —Scope of Board's Decision-Making Authority

3. **Program Instructions—Provider Reimbursement Manual (HIM 15-1):**

a. Chapter 1 —Depreciation

b. Chapter 2 —Interest Expense

c. Chapter 6 —Grants, Gifts, and Income from Endowments

d.	Section 802	—Definitions
e.	Section 804	—Accounting Treatment
f.	Section 806	—Contributions by Vendors
g.	Chapter 10	—Cost to Related Organizations
h.	Section 2102.1	—Reasonable Costs
i.	Section 2102.2	—Costs Related to Patient Care
j.	Section 2102.3	—Costs Not Related to Patient Care
k.	Section 2105.2	—Cost of Meals for Other Than Provider Personnel
l.	Sections 2108ff	—Reimbursement for Services by Provider-Based Physicians
m.	Section 2145	—Cost of Meals for Provider Personnel
n.	Sections 2163ff	—Malpractice Costs
o.	Section 2302.4	—Allocable Costs
p.	Section 2302.5	—Applicable Credits
q.	Section 2302.7	—Cost Finding
r.	Section 2302.8	—Cost Center
s.	Section 2302.9	—General Service Cost Centers
t.	Section 2304	—Adequacy of Cost Information
u.	Section 2310	—More Sophisticated Methods

v. Section 2328 —Distribution of General Service Costs to Nonallowable Cost Area.

CONCLUSIONS AND FINDINGS:

The Provider Reimbursement Review Board (Board), after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and the posthearing briefs, concludes and finds as follows:

Issue 1—Snack Bar:

The Board finds that substantial evidence in the record demonstrates that costs of materials and labor for the snack bar were reported in the dietary cost center. Accordingly, the Intermediary's reclassification of such costs to the snack bar cost center was appropriate to assure the correct assignment of costs to the benefiting activity and to permit the proper allocation of indirect costs.

The Board finds that the Provider did not support its claims with either verifiable records or other evidence. The provisions of 42 CFR 405.406 and 405.453 require providers to maintain verifiable and auditable financial records and statistical data to support costs claimed. Because of the total lack of such records, the Board finds that the Intermediary's use of data furnished by the Provider's outside contractor was a reasonable and responsible attempt to use data from an independent source. The Board concludes that the Intermediary was correct in utilizing such available verifiable data and finds that the methodology it applied in making its reclassification adjustment was an acceptable alternative in view of the deficient Provider records.

In addition, the Board finds that the Provider's accounting and statistical records are inadequate and unsupported by proper documentation to permit a reasonable and accurate calculation of the unrecovered costs of employee meals. Also, the Board finds

that there is no evidence to support extrapolation of the 1981 data to the prior years. Such an approach appears to be contraindicated due to the unexplained and wide variations from year to year of revenues, costs, and statistics. Also, the records of the snack bar and gift shop were commingled for all years. Although the Provider's determination that 65 percent of the snack bar's activity relates to employee utilization may appear plausible, the numerous inconsistencies from year to year coupled with the commingling of the revenues and costs of the gift shop with those of the snack bar renders the retroactive application of that approach unreasonable and inappropriate. The Board finds that the Provider has failed to present any evidence to support its position. Finally, because snack bar and cafeteria operations were combined and the outside contractor's services were discontinued in 1981, the 1981 data reflected operations which could not be compared with those of the prior reporting periods for any practical purpose.

Issue 2—Inpatient Consultation Income:

The Board finds that the Intermediary failed to provide any evidence to substantiate that the alleged inpatient consultation fees were charged to patients. The Board notes that the Intermediary has agreed to restore a sizeable portion of its original adjustments based upon subsequent findings and the testimony and evidence presented at the hearing. In the absence of records or other documentary evidence to support its findings, the Board concludes that the Intermediary's adjustments must be restored to the Provider in their entirety for all cost reporting periods in contention.

Issue 3—Malpractice Insurance:

The Board finds that 42 CFR 405.452(b)(1)(ii) requires that malpractice insurance costs be separately accumulated and directly apportioned to Medicare rather than averaging the costs in the stepdown, cost finding process and apportionment. The Board is bound by that regulation.

Issue 4—Foundation Contributions/Income

The Board finds the Intermediary's adjustments, for the most part, are a correct application of Medicare policy. The Foundation and the Provider were related organizations as set forth in 42 CFR 405.427. The Foundation and the Provider were involved jointly in transactions which impacted on costs associated with the provision of patient care services. The record shows that most of the contributions by Provider vendors to the Foundation had been offset as rebates against the associated costs in the cost reports filed by the Provider. The Board finds that those vendor contributions which were not offset by the Provider and, therefore, which were included in the Intermediary's adjustments, must be offset against the costs to which they relate consistent with the provisions of 42 CFR 405.425ff and Section 806 of HIM 15-1. Also, the Board finds the Provider's treatment of vendor contributions as rebates is tacit acknowledgement that the Intermediary's adjustments were proper.

The Board finds that the physicians' contributions are subject equally to the provisions of Section 806 of HIM 15-1 and must be treated as rebates and cost offsets to the extent that the Provider incurred costs related to the physicians' activities and against which a recovery, therefore, is appropriate. The evidence demonstrates that the contributions, generally, were made in lieu of rental payments and were related to the amount of the physicians' compensation. The Provider has presented no evidence either to refute the Intermediary's determinations or to allow the Board to consider an alternative treatment.

The Board finds that the Intermediary has failed to identify the source of the miscellaneous contributions except to label them as "no auditable detail" and "miscellaneous." In the absence of evidence as to the nature of these contributions, the Board concludes that the Intermediary has no basis to support its adjustment and, therefore, the miscellaneous contributions adjustment must be reversed.

The Board finds the Intermediary's adjustments offsetting the Foundation's investment income against the Provider's interest expense to be unsupportable based on the evidence presented. The Intermediary has failed to show that the borrowings were unnecessary as required by 42 CFR 405.419ff. The Board finds the amount of income from the Provider's telephones, televisions, gift shop, and other activities was nominal. The diversion of cash from this income to the Foundation instead of to the Provider had no material effect on the Provider's working capital or cash flow. Therefore, the diversion can not be construed to be a cause of unnecessary borrowing. The record shows that the Foundation's investment income was earned, in the main, on the substantial amounts of its own funds from the proceeds of gifts, grants, and other sources unrelated to Provider operations.

The Board disagrees with the Intermediary's argument that all assets of the related Foundation entity must be considered available to the Provider to determine whether a borrowing might be necessary. The record demonstrates that the investment income is not related to the Provider and, therefore, should not be offset against the Provider's interest expense.

Issue 5—Funded Programs:

The Board finds that the three funded programs involved activities not related to patient care services and their costs must be classified in a nonallowable cost center. As a separate cost center, the funded programs' costs are subject to the cost finding process. The Board concludes that there is substantial evidence that the funded programs received services from the Provider. Therefore, the costs associated with the Provider's general service cost centers must be allocated to the funded programs' nonallowable cost center. The Provider has not presented evidence to support the use of an alternative allocation method.

Issue 6—Interest/Depreciation Expense:

The Board finds there is substantial evidence in the record to demonstrate that the transactions consummated through the sale of MHC stock and the amendment to the corporate status of MHC from forprofit to not-forprofit was based on a preconceived

plan which had been formulated a number of years prior to the May 19, 1975 transaction date.

For example, the goal of the Foundation was expressed at the Trustees Meeting of July 16, 1974:

> ". . . It was recalled from the minutes of February 12, 1969 and subsequently each year thereafter that the Foundation goal was to purchase the Monsour Hospital and Clinic at Fair Market Value in 1975. This would be accomplished with a small down payment and a 20 year payout. The new voluntary hospital would be called the Monsour Medical Center and would have its own Board of Directors appointed by the Monsour Medical Foundation Trustee's. Legal steps are underway to accomplish this in early 1975. . . ."

The Board finds that the evidence demonstrates that the new trustees of the Foundation, who approved the transaction at the May 19, 1975 meeting, were acting as surrogates of the Family to implement the final stages of a corporate long-term plan which had been adopted by the Foundation in a prior period when it was controlled by the Monsour family. Even the names and the terms of the transactions were the same as those specified in the 1969 corporate "goal" statement in the 1974 minutes. There is no question that the Family, the Foundation, and the MHC were related when the entire transaction was specifically planned. The fact that the transaction was executed almost precisely as planned demonstrates the continuation of substantial control in fact.

The Board finds that the transactions were effected as an ordinary sale and purchase of stock between the stockholders of MHC, the Family, and the Foundation. That final transaction, also, was essentially the same as the plans that were made years prior with adjustment for updating using the appraised values. There is no doubt from the record that the stockholders of MHC and the members of the Foundation during that corporate long-term planning period were related parties under the provisions of 42 CFR 405.427. Thus, the stock transactions are not arm's-length transactions between unrelated parties.

In response to the Intermediary's argument that the Monsour family appointed the members and directors of the Foundation and, therefore, controlled the Foundation, the Provider states the following in its posthearing supplemental position paper:

> ". . . Although this argument has some appeal in a commercial setting, it is nonsense in the non-profit setting generally . . ."

The Board concludes that the Family organized and operated both MHC and the Foundation "in a commercial setting." First, for years MHC was a forprofit corporation in a "commercial setting." Second, the Foundation insured the investment value and the estate of each stockholder with a guarantee of the marketability of Family stock in the event of the death of any stockholder. The Foundation trustees on April 11, 1972 adopted the following motion:

> ". . . that the officers of the Monsour Medical Foundation be authorized to enter into an Agreement with all of the stockholders of Monsour Hospital & Clinic, whereby it would be agreed that the shares of stock of the Monsour Hospital & Clinic would, upon the death of a stockholder, be sold to the Foundation at the fair market value of the stock and the Foundation would pay the estate of the deceased stockholder for said stock, the consideration over a period of twenty (20) years with an interest rate payable on the unpaid balance due the estate to be negotiated and set forth in the Agreement with the understanding, however, that the interest rate is not to exceed six (6%) per cent per annum on the unpaid balance. The Foundation's officers or representatives are, by this Resolution, authorized to execute all and any necessary papers to effectuate the purpose of this Resolution. . . ." (Intermediary's Exhibit I-3—507)

Third, the Board finds that a transaction involving the sale of a forprofit hospital corporation's stock whereby the stockholders stand to make a sizeable financial gain cannot be viewed as anything but one conducted in a "commercial setting."

The Board finds that there is nothing in the record to show that a sale or transfer of land or depreciable assets ever occurred. The conversion was effected through a sale and purchase of stock transaction between related parties followed by a reorganization of the hospital's corporate form under State statutes. The for-profit hospital corporation was not liquidated subsequent to the sale of stock. In fact, the corporation continued to function under new colors. Thus, the Board concludes this is not a transaction that would result in a stepped-up basis of the Provider's depreciable assets. Furthermore, the Board holds that the interest expense which was incurred to finance the purchase of Family stock is not related to patient care. The Board finds that the Intermediary's disallowances of depreciation and interest expense are consistent with the provisions of 42 CFR 405.415 and 405.419 and are sustained.

DECISION:

Issue 1—Snack Bar:

The Intermediary's specific allocation of dietary department costs to the Provider's snack bar was correct. The Intermediary's adjustments for all years in contention are affirmed.

Issue 2—Inpatient Consultation Income:

The Intermediary's adjustments offsetting the Provider's inpatient consultation income against the Provider's general operating costs were not correct. The Intermediary's adjustments for all cost reporting periods in contention are reversed.

Issue 3—Malpractice Insurance:

Regulation 42 CFR 405.452(b)(1)(ii) requires that malpractice insurance costs be separately accumulated and directly apportioned to Medicare. The Board is bound by that regulation. The Intermediary's adjustments stand.

Issue 4—Foundation Contributions/Income:

The Intermediary's adjustments reducing the Provider's costs by the amount of vendors' and physicians' contributions to the Monsour Medical Foundation are affirmed and are reversed

as to the amounts pertaining to miscellaneous contributions and interest income.

Issue 5—Funded Programs:

The Intermediary was correct in determining the costs of various funded programs operated by the Provider by establishing a nonallowable cost center instead of accounting for the costs of such programs through the use of a revenue offset. The Intermediary's adjustments are affirmed.

Issue 6—Interest/Depreciation Expense:

The Intermediary's disallowance of the Provider's second mortgage interest and associated "stepped-up" depreciation expense was correct. The Intermediary's adjustments are affirmed.

Board Members Participating:

Paul Morton Ganeles
Richard A. Dudgeon
Barbara J. Sinnott

FOR THE BOARD:

JUNE 14, 1984

/s/ RICHARD A. DUDGEON
Richard A. Dudgeon
Acting Chairman

APPENDIX D

491 A.2d 914 (1985)

BLUE CROSS OF WESTERN PENNSYLVANIA, A PENNSYLVANIA NON-PROFIT CORPORATION, *Appellant*	:	IN THE SUPERIOR COURT OF PENNSYLVANIA
v.	:	Pittsburgh Office
MONSOUR MEDICAL CENTER, MONSOUR HOSPITAL AND CLINIC, INC., WILLIAM MONSOUR, HOWARD MONSOUR, ROY MONSOUR, ROBERT MONSOUR AND EVA MONSOUR	:	No. 01413 Pittsburgh, 1983
BLUE CROSS OF WESTERN PENNSYLVANIA, A PENNSYLVANIA NON-PROFIT CORPORATION,	:	IN THE SUPERIOR COURT OF PENNSYLVANIA
v.	:	Pittsburgh Office
MONSOUR MEDICAL CENTER, MONSOUR HOSPITAL AND CLINIC, INC., WILLIAM MONSOUR, HOWARD MONSOUR, ROY MONSOUR, ROBERT MONSOUR AND EVA MONSOUR, *Appellants*	:	No. 01479 Pittsburgh, 1983

Appeal from the Order of the Court of Common Pleas,
Allegheny County, Civil Division,
at No. GD82-4968.

Before: BROSKY, WATKINS and HESTER, *JJ*.

PER CURIAM: FILED: JANUARY 25, 1985

Order affirmed.

BLUE CROSS OF WESTERN PENNSYLVANIA, A PENNSYLVANIA NON-PROFIT CORPORATION,	:	IN THE SUPERIOR COURT OF PENNSYLVANIA
Appellant	:	Pittsburgh Office
v.	:	
MONSOUR MEDICAL CENTER, MONSOUR HOSPITAL AND CLINIC, INC., WILLIAM MONSOUR, HOWARD MONSOUR, ROY MONSOUR, ROBERT MONSOUR AND EVA MONSOUR	:	No. 01413 Pittsburgh, 1983
BLUE CROSS OF WESTERN PENNSYLVANIA, A PENNSYLVANIA NON-PROFIT CORPORATION,	:	IN THE SUPERIOR COURT OF PENNSYLVANIA
v.	:	Pittsburgh Office
MONSOUR MEDICAL CENTER, MONSOUR HOSPITAL AND CLINIC, INC., WILLIAM MONSOUR, HOWARD MONSOUR, ROY MONSOUR, ROBERT MONSOUR AND EVA MONSOUR,	:	No. 01479 Pittsburgh, 1983
Appellants	:	

Appeal from the Order of the Court of Common Pleas,
Allegheny County, Civil Division,
at No. GD82-4968.

Before: BROSKY, WATKINS and HESTER, *JJ*.

MEMORANDUM:

This appeal and cross-appeal are from an Order entered subsequent to a non-jury trial in a civil case involving the conversion of a proprietary hospital into a non-profit corporation. The opinion of the Court of Common Pleas adequately disposes of the eleven issues raised by appellant and of the eleven issues raised by the appellee/cross-appellant, and no further discussion is necessary.

Order affirmed.

APPENDIX E

BLUE CROSS OF WESTERN PENNSYLVANIA,
a Pennsylvania non-profit corporation,
Plaintiff,

vs.

MONSOUR MEDICAL CENTER, MONSOUR HOSPITAL AND CLINIC, INC., WILLIAM MONSOUR, HOWARD MONSOUR, ROY MONSOUR, ROBERT MONSOUR AND EVA MONSOUR,
Defendants.

IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA

CIVIL DIVISION

No. GD 82-4968

Filed By:
Gary J. Kushner
Official Court Reporter

Trial Date:
February 2, 1983

Trial Judge:
Hon. I. Martin Wekselman

Trial Transcript
February 2, 1983
10:15 o'clock A. M.

THE COURT: I apologize for the delay. As Mr. Vilage may have told you, I had to fill in for Judge McGowan this morning at the call of the list. As usual, there were tons of motions.

We will now proceed as indicated yesterday to disclose the non-jury decision of the Court and the basic reasons for it so that counsel may be guided in the institution of such post-verdict or post-decision proceedings as they choose to undertake.

In this action the plaintiff, Blue Cross of Western Pennsylvania, seeks relief in a five-count complaint.

First count of the complaint alleges fraud and deceit.

Second count alleges negligent misrepresentation of certain facts which were allegedly relied upon by Blue Cross to its detriment.

Third count is in assumpsit and alleges a breach of contract or a mutual mistake of fact. That count is against Defendant Monsour Medical Center only.

Fourth count alleges unjust enrichment against the individual defendants only.

Count five seeks a declaratory judgment which would declare that the conversion transaction involved in the litigation was not an event which made conversion expenses allowable for reimbursement purposes.

Defendants have filed a counterclaim in four counts.

The first count seeks a declaratory judgment which is the other side of the coin of count five of plaintiff's complaint.

The second count seeks the same basic relief on the theory of estoppel.

Third count alleges defamation.

The fourth count alleges a tortious interference by plaintiff with contractual relationships between the Monsour Medical Center and the individual defendants.

The entire controversy revolves around the conversion of the Monsour Medical Hospital and Clinic, Inc., from a proprietary hospital owned and operated by the individual defendants to a voluntary hospital known as the Monsour Medical Center.

It is the basic contention of plaintiff that the conversion was not an arm's length transaction between or among unrelated parties and that effective control of the entity remained in the individual defendants subsequent to the conversion. For that reason plaintiff has disallowed reimbursement to the Medical Center for conversion-related expenses, specifically depreciation allowances on the stepped-up value of the assets which followed the conversion and interest expenses on a second mortgage held by the individual defendants as part of the conversion for the alleged sale of the assets by them to the Medical Center.

Defendants, of course, contend that the transaction was an arm's length sale and that control of the institution now resides in the Medical Center Board of Directors and that the conversion expenses are properly reimbursable by Blue Cross both in its private capacity on behalf of its subscribers and in its capacity as fiscal intermediary for the Medicare program of the United States Government.

Defendants further contend that even if the conversion is not found to be an arm's length transaction, Blue Cross is nevertheless estopped from refusal to reimburse the conversion-related costs.

The Court could proceed in a number of ways in this matter and become involved in arcane positions of the applicable law. For example, the Court might find that the conversion did not meet the guidelines established in the applicable Medicare regulations and that the conversion-related expenses are, therefore, not reimbursable. On the other hand, the Court might find that even though the conversion did not meet the Medicare guidelines for an arm's length transaction, the interest costs would nevertheless be reimbursable. Such a finding is certainly arguably possible on the authority of South Boston General Hospital versus Blue Cross of West Virginia where the Court struck down the automatic application of the related parties doctrine. Such a ruling would also be in conformity with the decision of the United States Court of Appeals for the Seventh Circuit which held in Northwest Hospital, Inc., versus Hospital Services Corporation, 687 Fed. 2d 985, that to finance a sale consistent with the purposes of the Medicare program, funds must be supplied from some source. The supplying of such funds inescapably involves the interest cost, and it is entirely possible that the only available source of funds will be the sellers who are related parties. In such a case it would be egregiously unjust as well as contrary to the terms of the Medicare statute to disallow this inescapable interest cost. Hence, the application of the challenged regulation facts of that case was found to be unreasonable and invalid.

Before reaching such conclusions of law, however, the Court should from the evidence present determined facts. It is

only after the facts have been determined that the Court will be in a position to apply the law to the facts as found.

Testimony in this case was heard for some 12 or 13 days.

The initial question to be determined is whether that evidence supports a finding that the conversion which occurred in May of 1975 was an arm's length transaction within the guidelines established by the Medicare regulations. At this point it should be noted that the parties are in agreement that the Medicare regulations govern the determination of that question and dictate whether the disputed costs are reimbursable by Blue Cross in either of its reimbursing capacities.

The evidence discloses that the four Monsour brothers, each of whom is a physician, established the Monsour Medical Foundation and the Monsour Hospital and Clinic, Inc. The Court will not become involved in the wisdom of the activities of the Monsour Medical Foundation and the motivation of the founders of that Foundation. Suffice it to say that a hospital was established which grew from very humble beginnings to a community hospital of considerable size offering medical services of a highly complex nature and variety. The Foundation involved itself in a number of civic and educational activities in the medical field and provided scholarships for both medical and nursing students as well as engaging in research in varying kinds and other related activity.

From the very beginning of the hospital and clinic it was the intention of its proprietors to convert it into a voluntary hospital. By doing so, they could obtain certain benefits which were otherwise not available. No one complains that the conversion without more was in any way improper.

In any event the possibility of conversion finally came on the scene and it was pursued through the employment of legal representatives to perform the necessary acts to make the conversion work. Application was made to the Attorney General of Pennsylvania and to the Internal Revenue Service for the necessary approvals which were forthcoming in due course. At some point it became apparent to those involved that the approval of the conversion by Blue Cross would be necessary. Without such

approval, the reimbursements to the hospital would be insufficient to permit the resulting entity to be economically viable.

The initial proposal was not satisfactory to Blue Cross and Blue Cross made clear to those involved that the Medicare guidelines required that the transaction be at arm's length among unrelated parties and that control of the resulting voluntary hospital could not be in the form of proprietor.

With that in mind, the Monsours engaged the services of James and John Houston who, although they were not expert in the field of hospital reimbursement by third-party payers, were expert in the tax field. Many complications developed, both in the tax field and in the related party question. There were problems with establishing that there was an actual sale of assets rather than exchange of stock. The Houstons quite properly wished to avoid the necessity of paying real estate transfer taxes which would have been considerable. Further, they wished to achieve installment payment tax treatment for the sellers. Further, they were concerned about the existing first mortgage to Metropolitan Life Insurance Company and the possibility that an improperly structured conversion would constitute a default under that mortgage.

In any event they were able to work out a structure which was satisfactory to the Internal Revenue Service and the appropriate agencies of the government of the Commonwealth of Pennsylvania. In addition, they structured a reorganization of the governing bodies of the hospital and Foundation and informed Blue Cross by letter that control of the hospital would henceforth be in an independent Board of Directors and that the Monsour Medical Foundation would be controlled by a Board of Directors expanded to 13 members. They further reported to Blue Cross that Dr. William Monsour, who was the driving force behind the hospital and clinic as well as the Foundation, would no longer exercise control. They represented that he would no longer serve as president of the medical Foundation and that he would instead serve as Chairman of the Board with the sole duty of presiding at meetings.

The Houstons laid out an agenda for the conversion which in essence provided for the expansion of the medical Foundation

Board from its then five members, they being the original incorporators of the Foundation, to 13 members. The newly expanded Board of Directors of the Foundation then appointed a Board of Directors for the resulting medical center which it was represented would actually control the operations of the hospital. It is contended by defendants that that arrangement was orally approved by Blue Cross representatives in a telephone conversation between the then hospital administrator, Ben Razon, and Edward Marinac of Blue Cross a day or two before the meetings at which the conversion was approved by the Foundation and the new hospital Board.

Be that as it may, however, in July of 1975 Blue Cross did formally grant conditional approval to the conversion. The condition imposed was that the final approval would hinge upon an audit of the first year of operation of the medical center. Thereafter, a special audit of the operation of the center was undertaken by Blue Cross. That special audit was eventually at least put in abeyance on orders from Jackson Lynch of Blue Cross to Marinac. At no time was there any communication by Blue Cross to the medical center that the audit had been concluded or that the conditional approval had become unconditional.

Between the time of the conversion and the at least temporary abandonment of the special audit, a number of problems arose. Among those problems was the valuation of the medical center's assets for depreciation reimbursement purposes.

The transaction between the owners of the former proprietary hospital and the voluntary hospital involved the following basic elements: The Monsours donated 50 percent of their ownership interest to the medical center; the other 50 percent of their ownership interest was sold to the medical center for $500,000 in cash and a second mortgage in the amount of 7.5 million with interest at the rate of six percent per annum for the first five years and at the prime rate charged by Mellon Bank for the remaining term of the mortgage. The center, of course, contended for a stepped-up valuation of its assets well above the then book value of the assets as carried on the books of the clinic.

Disputes arose as to whether the historical asset value should be used or whether an appraisal at a much, much higher value should be used.

In any event, in February of 1977 an agreement was reached. The evidence indicates that Jackson Lynch of Blue Cross agreed to a valuation of 5.2 million for depreciation reimbursement purposes and that compromise was accepted by the medical center.

Further problems arose with respect to the reimbursability of other hospital costs. For example, Blue Cross sought to and did recover sums previously paid to the hospital on the basis of donations made to the Foundation by parties who provided services to the center. There were questions involving revenues from the snack bar and from television rentals in the hospital which were being channeled into the Foundation rather than the hospital. Members of the medical center of the hospital were making donations to the Foundation under circumstances which caused Blue Cross to seek the recapture of sums previously reimbursed to the hospital.

The hospital's record keeping might most charitably be characterized as chaotic. All of this led to the hospital finding itself in very serious financial difficulty. The matter proceeded to the point that the Internal Revenue Service which had a lien for unpaid unemployment taxes and income tax withholding levied on the hospital's bank accounts and on any amounts which would have come from Blue Cross' third party payer reimbursements. Faced with those levies, the hospital in February of 1980 filed a proceeding in the United States Bankruptcy Court under Chapter 11 of the Bankruptcy Act.

Disputes then arose with respect to Blue Cross' continuing attempts to recapture previously reimbursed funds and payment to the Internal Revenue Service of the sums owed by the hospital which formed the basis for the levies. Litigation ensued in adversary proceedings in the Bankruptcy Court between Blue Cross and the hospital. This led to voluminous discovery in which it is asserted by Blue Cross it first learned that actual control of the voluntary hospital remained in its former proprietors. It, therefore, reached the conclusion that the conversion did not

meet the guidelines established by Medicare and that the conversion-related expenses were not reimbursable and that such reimbursements as had been made from the time of the conversion should be recaptured. That decision, needless to say, led to the present litigation.

The evidence is clear that from the time of the conversion many officials of Blue Cross were suspicious of its bona fides. People concerned with the audit function of Blue Cross, both in its private capacity and as fiscal intermediary for Medicare, suspected that Dr. William Monsour was in effective control of the voluntary hospital just as he had been in effective control of its predecessor proprietary hospital. Jackson Lynch in his overall supervisory capacity kept asking those in the auditing department to bring in facts upon which he could base such a conclusion. No such facts were, however, forthcoming. Mr. Marinac continued his activities until such time as a complaint of harassment was made to Lynch. Lynch then instructed Marinac to discontinue the special audit.

During the course of that special audit, Marinac followed every lead that he came upon. For example, he heard rumors that the brothers Monsour were being favored by admissions to their individual services from the emergency room of the hospital. He checked that out and found that no such favoritism existed. Many more examples exist of the matters which were looked into by various Blue Cross officials, but the long and short of it is that they could turn up nothing which would enable them to come to a conclusion that actual control resided in the Monsours. Certain very interesting testimony exists in the record.

Dr. William Monsour's deposition indicates that he did not believe himself to be in control of the voluntary hospital. He conceded that he made many suggestions which were followed by both the Foundation Board and the hospital Board. He attributed that to his encyclopedic knowledge of the operations and his expertise which was relied upon by what he considered to be the governing bodies in reaching decisions concerning the operations of the Foundation and the medical center.

In the deposition of Ben Razon it appears that he was first employed by the brothers Monsour in December of 1970 as an accounting clerk. He testified that he was promoted by them in November of 1971 to the position of vice president for finances. That appointment was made by the then hospital administrator, Mark Goldberg. In February of 1975 he testified that Dr. William Monsour appointed him as acting executive vice president. Thereafter, in August of 1975, subsequent to the conversion, he was appointed executive vice president. This appointment, however, was made not by the Monsours but by the hospital's Board of Directors. He further testified that from time to time during his employment at the hospital subsequent to the conversion the second mortgage payments were not made and in fact at one point were at least a year behind.

In connection with that, it might be said that there was much testimony concerning payment of the second mortgage. Mr. Lowenhagen testified, for example, that the second mortgage was delinquent some $400,000 during his term at the hospital. Payments were being made, but at a much lower rate than required by the mortgage document.

Blue Cross sought to establish that Dr. William Monsour was giving orders with respect to the payment of the second mortgage. The testimony does not support that contention. The testimony indicates instead that Dr. William Monsour from time to time made requests of responsible hospital officials that second mortgage payments be made. Despite those requests, the payments were skipped from time to time and eventually went into serious arrearage.

Dr. Robert J. Nossen was called as plaintiff's witness. Dr. Nossen, after the conversion, became the president of the Foundation Board and an ex officio member of the hospital Board. During his tenure in that position, the Foundation bylaws were amended to give the Foundation Board control over the membership and actions of the hospital Board. It was he who conceived the idea of having an Executive Committee of the Foundation and he who requested that Dr. William Monsour serve on that Board. He testified clearly that the change in the bylaws was not conceived for control purposes and that it did not

work that way in practice. He further testified that the Executive Committee of the Foundation was not intended to nor did it run the hospital and that it reported always to the Foundation Board.

He was able to point to only two instances in which he asserted that Dr. William Monsour controlled the operations of the hospital. The first instance involved the decision of the hospital Board to close the Drug and Alcohol Rehabilitation Unit of the hospital. His testimony was that despite that order the unit was not closed because Dr. William Monsour refused to permit it to be closed. On cross-examination, however, it appeared that Dr. William Monsour appeared before a hospital Board meeting and convinced the Board of the lack of wisdom of its decision to close the unit. The second instance involved a decision by the Board and its order to Ben Razon to implement certain staff reductions. Those instructions were not followed by Ben Razon assertedly because Dr. William Monsour objected. Once again on cross-examination it appeared that Dr. William Monsour appeared before the Board and convinced them that the savings which they had expected would result from the staff reduction would not be as great as they had anticipated and that medical services would suffer. The Board then rescinded its previous order.

In concluding his direct examination, Dr. Nossen asserted that Dr. William Monsour's all pervasive influence led to his resignation. That assertion was considerably weakened on cross-examination. He testified on cross that the funding of a commission which was a pet project of Dr. William Monsour was cut from $90,000 to $38,000 despite Dr. William Monsour's objections. He further testified that each of the members of the Board was to a greater or lesser extent independent and vocal and willing to make his or her opinions known with the exception of five as to whom he could express no view but as to whom he had no indication of lack of independence. He further testified on cross-examination that his resignation was based in part on the financial condition of the institution which caused him to receive calls from creditors and adverse reactions from colleagues at the University of Pittsburgh where he was employed as associate provost because the University was not receiving funds which had been promised to it by the Foundation for research purposes.

Finally, Dr. Nossen's value as a witness for the proposition that Dr. William Monsour was in control was weakened almost to the vanishing point by his testimony on redirect examination that Dr. William Monsour was able to exert such control as he asserted because he "convinced and persuaded" those who made the decisions.

Richard K. Welch who spent 60 days as hospital administrator testified that despite the fact that Dr. William Monsour was not in agreement with the filing of the bankruptcy proceeding or the hiring of an outside management agency, those matters were accomplished.

Another witness upon whom plaintiff places heavy reliance is John Foos. Mr. Foos is a certified public accountant with the nationally known accounting firm of Peat, Marwick, Mitchell. He appeared as an expert witness and offered his opinion that in accordance with the generally accepted accounting principles the conversion transaction should not have been accounted for at a stepped-up value since the parties to the conversion were under common control. He concluded that the Foundation and clinic were one and the same. His conclusion that the transaction should not have been accounted for at the stepped-up value and that the interest on the second mortgage is not an allowable cost for reimbursement purposes begs the question since it is based on his conclusion that the parties were under common control. That, of course, is the ultimate question which must be determined by this Court on the evidence at hand.

Mr. Foos opined that the conversion did not meet the Medicare guidelines since the former proprietors retained the ability to significantly influence the resulting voluntary hospital. When questioned about the meaning of ability to significantly influence, he indicated that that meant that the parties previously in control were in a position to impose their views on the successor body.

During the course of Mr. Foos' testimony, the Court made an analogy. The Court inquired as to whether Mr. Foos conceived the power to impose its will as distinguished from convincing and persuading as analogous to the difference between the President of the United States telephoning members of the

Congress in order to persuade them to support a particular piece of legislation and the direction by the Chancellor of the Third Reich to the Reichstag as to what legislation it would enact. He replied that the analogy was apt.

James H. Joseph, former counsel for the medical center, also testified as a witness for plaintiff. He testified that the reduction of the hospital Board much relied upon by plaintiff as an indication of the control of the Monsours and referred to commonly in the testimony as the April Massacre was his idea. He testified that although Dr. William Monsour believed that the hospital Board was about to retain the services of Hospital Affiliates International as management agent, Mr. Joseph believed that they were about to retain Hospital Corporation of America in that capacity. Mr. Joseph did not believe that the retention of Hospital Corporation of America was in the best interests of the hospital. He, therefore, went to another of the Monsour brothers and convinced him of the necessity of reducing the size of the Board so that the proper managing agent would be retained. He further believed that a reduction of the Board would solve many management problems imposed on the hospital by the Chapter 11 proceeding.

It might be pointed out at this point that the filing of the Chapter 11 proceeding was against the express wishes of Dr. William Monsour. Mr. Joseph, however, determined that the ultimate authority was in the hospital Board and he received the approval of that body in connection with the filing of that proceeding.

He further testified that Dr. William Monsour did call him on many occasions and asked him to convince Mr. Lowenhagen to do some things, including payments on the second mortgage.

This hardly indicates the kind of control which Mr. Foos believed to exist.

In fact Mr. Joseph could really not point to any major issue in which Dr. William Monsour controlled the activities of the hospital Board.

We turn now to the reorganization of the Foundation Board which occurred in connection with the conversion in May of 1975.

Plaintiff makes much of the fact that the reorganization was not accomplished in accordance with the provisions of the Pennsylvania Not-For-Profit Corporation Act. Plaintiff contends that proper notices were not given and the proper procedures were not undertaken for obtaining the consent of the then members of the Foundation Board. Specifically, plaintiff contends that Mrs. Eva Monsour was never consulted and that the one consultation by phone made with one of the Monsour brothers was not done with proper equipment so that all the members of the Board could participate.

Plaintiff relies heavily on the decision of the Pennsylvania Supreme Court in Stone versus American Lacquer Solvents Company, 345 Atlantic 2d 174. That reliance is misplaced.

In Stone, the widow of a director who would have been the beneficiary of certain benefits contended that the action of the corporation Board which deprived her of those benefits was irregular and unenforceable. The Court agreed in circumstances similar to those at bar. The Court stated pertinently, "If they purport to act at a meeting which is not a regular meeting, their action is not that of the corporation and the corporation absent ratification or acquiescence is not bound."

Here the evidence is overwhelming of ratification and acquiescence. No member of the original Board complains that the expansion of the Board which occurred in May of 1975 was improper. In fact by the very defense of this lawsuit they have ratified and acquiesced in that action. Moreover, it is difficult to envision the standing of Blue Cross to raise that irregularity. It is clear from the evidence that there was an intention to enlarge the Board of the Foundation and that that enlargement actually occurred, albeit without the strict formality required by the statute.

Martin Dolence testified for the plaintiff to the effect that subsequent to the conversion the agendas for meetings of the Foundation Board were prepared by Dr. Nossen and not by Dr. William Monsour.

In the defendants' case all of the witnesses sought to establish that control changed subsequent to the conversion. Various members of the current Board were called to establish how they

became members of the Board and how they functioned. It was the Foundation Board which determined that Dr. William Monsour should step down as Chairman of the Board and Dr. William Monsour did so, although reluctantly.

Philip Johnson, senior vice president of Blue Cross, in a somewhat intemperate deposition indicated his view that Dr. William Monsour remained in control but was unable to articulate the facts upon which that conclusion was based. In fact throughout the testimony no one was able to articulate the facts upon which Blue Cross' disallowance decision was made. There were general references to the control which remained in the Monsours, but this Court cannot find from this evidence that such control exists. In fact the evidence convinces the Court to the contrary.

This Court finds as a fact from the evidence that subsequent to the conversion, control of the Foundation was in the Foundation Board and control of the hospital was in the hospital Board and that such control remains.

Dr. William Monsour is undoubtedly influential, but his influence is based upon his powers of persuasion and his superior knowledge of the operation of the Foundation and of the hospital. It was never intended that control of the hospital continue in the Monsours subsequent to the conversion nor has such control continued in fact. Neither Dr. William Monsour nor any other Monsour had the power significantly to influence the activities of the Foundation and hospital subsequent to the conversion or to impose his or their will on the respective Boards of Directors. What was intended to be done was actually done both in law and in fact.

Before concluding, the Court has constrained the comment on Blue Cross' contention that all of the new members of both the Foundation and hospital Boards were somehow related to the Monsours. Without cataloging the degrees of affinity or consanguinity involved with cousins of various distance or in-laws of various kinds, the Court is not impressed by that contention. Blue Cross basically contends that all of the members of the new Boards had some prior connection with the Monsours. One is a

cousin; how close a cousin is not disclosed. One is the brother-in-law of Dr. William Monsour's wife. He might also be called Dr. William Monsour's sister-in-law's husband. Others had various social or business relationships with the Monsours prior to their becoming members of one or the other of the Boards.

The Court can only say that it would be most surprised if it were to find that the Monsours chose total strangers to serve on these important governing Boards. There is certainly no surprise in selecting people to serve in these important capacities who are known from previous associations to be thoughtful and reliable. In essence, there is no evidence in this case from which the Court can find that the members of the two Boards were in any way beholding to the Monsours by virtue of prior social, business or family relationships with them, and the fact of such relationships is insufficient alone or in combination with any or all of the other evidence in the case to support a finding such as that contended for by Blue Cross.

Although it is not necessary to the decision of this case and the Court specifically eschews such a finding, one might well be justified in saying that the only thing that changed between the time of the conversion and its conditional approval and the time of the disallowance of the conversion expenses for reimbursement purposes was the interest rate of the second mortgage. That, of course, was an event unforeseen by anyone. Who could have predicted in the spring of 1975 that interest rates would escalate to the alarming degree that occurred by the summer of 1980. It would appear and one could find that Blue Cross made the correct decision with respect to the conversion when it issued its conditional approval, and were it not for the fact that the interest rates escalated so alarmingly, this litigation would never have occurred.

Having concluded that the conversion was in fact an arm's length transaction among unrelated parties, it follows that count one of plaintiff's complaint charging fraud and deceit must be determined in favor of defendants. The asserted misrepresentations in that count have proven not to have been misrepresentations at all.

The same thing then applies to count two for negligent misrepresentations. Obviously, if there were no misrepresentations, a count for negligent misrepresentation was failed.

Count three alleging a mutual mistake of fact also fails. There was no mistake of fact nor was there a breach of contract since the Court finds that the Monsours did precisely what they represented that they would do.

It follows additionally, then, that the individual defendants have not been unjustly enriched. They have entered into a bona fide arm's length sale of assets, and such monetary benefit as they have derived they are entitled to retain.

Finally, with respect to plaintiff's claim, count five, which seeks a declaratory judgment disallowing the conversion for reimbursement purposes, must be decided in favor of defendants.

Count one of defendants' counterclaim seeks a declaratory judgment that the conversion was a proper one for reimbursement purposes, and the Court so declares. In accordance with the evidence produced the Court will enter a non-jury decision for defendants who are plaintiffs on the counterclaim for $1,397,559 with appropriate interest at the legal rate. In addition, since the calculation of damages does not run to the date of this decision, Defendants' Exhibit 1071 shall be updated so that the non-jury decision is accurate to February 2, 1983.

Having determined that the conversion transaction was bona fide ab initio, there is no need for the Court to reach the issue of whether Blue Cross is estopped to deny its validity, and count two of defendants' counterclaim will be dismissed for mootness.

It will be recalled that the Court granted plaintiff's motion for compulsory non-suit with respect to the defamation count of the counterclaim, which is count three.

There remains only count four of the complaint which alleges tortious interference with contract rights and seeks both compensatory and punitive damages. The Court finds no basis for a finding of tortious interference with contract rights. First of all, the Court does not conceive the purpose of Blue Cross to have been such an interference. Blue Cross was acting to protect the rights of its subscribers, and any interference which might

have occurred is purely incidental. Moreover, the evidence does not actually disclose an interference with such rights. The Monsours are still collecting payments under their second mortgage. It is true that the second mortgage payments are in arrears, but that is not a new situation caused by Blue Cross. The mortgage payments were in arrears at many times before Blue Cross' decision to disallow the conversion expenses. Moreover, the Court cannot find that there was any bad faith on the part of Blue Cross and there was a reasonable basis, albeit mistaken, for Blue Cross to take the steps which it took. Therefore, a non-jury decision for Blue Cross on count four of the counterclaim will also be entered.

(Thereupon, the taking of the proceedings was concluded.)

APPENDIX F

BLUE CROSS OF WESTERN PENNSYLVANIA,
a Pennsylvania non-profit corporation
Plaintiff and
Counterclaim Defendant

v.

MONSOUR MEDICAL CENTER, MONSOUR HOSPITAL & CLINIC, INC., WILLIAM MONSOUR, HOWARD MONSOUR, ROY MONSOUR, ROBERT MONSOUR and EVA MONSOUR,
Defendants and
Counterclaim Plaintiffs.

IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA

CIVIL DIVISION

No. GD 82-4968

Issue No.

Code 011 — Assumpsit & Trespass

OPINION and ORDER OF COURT DISMISSING PLAINTIFF'S AND DEFENDANTS' EXCEPTIONS TO NONJURY DECISION

Filed by: WEKSELMAN, J.

October 28, 1983

OPINION

WEKSELMAN, J. October 28, 1983

Plaintiff filed an action of trespass and assumpsit against defendants. The Complaint consisted of five counts, the first of which alleges fraud and deceit on the part of defendants. Count 2 alleges negligent misrepresentation of certain facts which were allegedly relied upon by plaintiff to its detriment. Count 3,

which is against the Monsour Medical Center only, is in assumpsit and alleges a breach of contract or a mutual mistake of fact. Count 4 alleges unjust enrichment against the individual defendants only, and Count 5 seeks a declaratory judgment.

Defendants filed an Answer, New Matter, and Counterclaim in four counts. The first count, which is a mirror image of plaintiff's fifth count, seeks a declaratory judgment. Count 2 seeks the same basic relief on a theory of estoppel. Count 3 alleges defamation and Count 4 seeks damages for an asserted tortious interference by plaintiff with contractual relationships between the Monsour Medical Center and the individual defendants.

At the heart of the controversy is the conversion in 1975 of the Monsour Hospital and Clinic, Inc. from a proprietary hospital owned and operated by the individual defendants to a voluntary hospital known as the Monsour Medical Center. After a bench trial which consumed 12 or 13 days and produced a record nearly 2700 pages in length, the trial court entered a nonjury decision in the matter. That nonjury decision found in favor of defendants on Count 1 of plaintiff's Complaint charging fraud and deceit. The nonjury decision further found in favor of defendants on Count 2 of the Complaint which had asserted negligent misrepresentation. Count 3, which had alleged a breach of contract or mutual mistake of fact, was also decided in defendants' favor. The nonjury decision further found in favor of the individual defendants on Count 4 of the Complaint which had asserted that they had been unjustly enriched. Count 5 of the Complaint, the declaratory judgment count, was also decided in favor of defendants, the trial court having declared that the conversion of the hospital was proper and that the related conversion expenses were properly reimbursed.

With respect to the Counterclaim, the trial court found in favor of the counterclaimant defendants on Count 1 for declaratory judgment as indicated in the sentence next preceding, and entered a nonjury decision for defendants in the amount of $1,397,559 with appropriate interest. Having so determined, the trial court dismissed Count 2 of defendants' Counterclaim for mootness since there was no need to reach the issue of estoppel.

The trial court entered a compulsory nonsuit with respect to Count 3 of the Counterclaim, which had alleged defamation, and no party has taken exception to that portion of the nonjury decision. With respect to Count 4 of the Complaint, which had alleged tortious interference with contract rights, the Court found in favor of plaintiff as defendant in the Counterclaim. Both sides have filed exceptions to the nonjury decision.

Plaintiff filed 27 exceptions to the nonjury decision, some of which are repetitious of or restatements of other exceptions or are implicit in such other exceptions. Be that as it may, however, all of plaintiff's exceptions have been reduced in plaintiff's 70-page brief and argument to 11 specifications of error listed as A through K in the brief, some of which require explication and others of which have been fully discussed by the Court in its nonjury decision.

Plaintiff's first specification of error involves Rule 1029(b), Pennsylvania Rules of Civil Procedure. That rule, at least as it currently exists, requires specific denials of all well-pleaded allegations of fact contained in assumpsit complaints. The rule specifies that general denials will be construed to be admissions except in those instances where the factual averments have been denied by necessary implication. The matter came up during the course of trial when plaintiff sought to read certain paragraphs of the Complaint and the Answers thereto into the record as admissions by defendants. No real problems arose until plaintiff sought to introduce the general denial of paragraph 10 of the Complaint as an admission by defendants. That paragraph read:

> Members of the Monsour family have at all times since 1966 to the present had the power to and in fact controlled the Foundation and its activities and its Board of Directors by being the Members of the Foundation under the Foundation's By-laws and by having the power directly or indirectly significantly to influence the actions or policies of the Foundation.

The trial court refused to consider the general denial of that paragraph as an admission, ruling that it had been denied by necessary implication. The question of the power of the members of

the Monsour family directly or indirectly significantly to influence the actions or policies of the Foundation and/or Hospital was at the heart of the entire controversy and it was clear that the very nature of the lawsuit—to say nothing of the Counterclaim—indicated plainly that that allegation was denied and hotly contested. Had that paragraph of the pleadings been accepted as an admission by defendants, there would really have been no reason to try the lawsuit. This Court believes that the trial court was correct with respect to its rulings on admissions from the pleadings as they are contained in pages 74 through 116 of the trial transcript. The pleadings do not meet the technical niceties of the rules of civil procedure but there is no question that the issues in the case were properly framed therein.

Plaintiff next contends that under the applicable Medicare principles of reimbursement, the Monsour family controlled the Center and the Foundation after the conversion. That argument is in two parts. Part one asserts that the trial court misapplied the Medicare principles of reimbursement applicable to the conversion transaction, and part two contends that the trial judge overlooked or mischaracterized other evidence adduced at trial which establishes the Monsours' control over the Center and the Foundation after the conversion. First of all, the trial court did not misapply the Medicare principles of reimbursement applicable to the conversion transaction. The Court was well aware that the transaction could not be considered an arms-length transaction among unrelated parties where the transferors were in a position or had the power to significantly influence the operation of the resulting entity, even if no such actual control existed. The trial court found from the evidence not only that the Monsours did not control the transferee entity but that they did not have the power significantly to influence its operations. As to overlooking or mischaracterizing evidence, the trial court carefully reviewed all of the evidence and stated on the record the inferences which it drew from the evidence. Needless to say, plaintiff is disappointed that the Court did not draw inferences congenial to the position of the plaintiff, but the evidence clearly supports the inferences drawn by the trial court.

Plaintiff then contended that the trial judge misapplied the Pennsylvania Nonprofit Corporation Law with respect to the expansion of the Medical Foundation. That matter, too, was fully considered and covered by the trial judge in his nonjury decision at pages 2665-2667 of the trial transcript. This Court adopts the trial judge's discussion of that issue as its opinion with respect to that exception.

Plaintiff further argues that the trial judge used an improper standard for burden of proof in evaluating several of plaintiff's claims. It is, of course, true that fraud and deceit must be proved by clear and convincing evidence and that all of the other counts of the Complaint must be established only by a fair preponderance of the evidence. The Court applied no standard to any count of the Complaint, except the fraud and deceit count, other than the fair preponderance of the evidence standard. Fraud and deceit were not only not proved by clear and convincing evidence, but they were not proved by the fair preponderance of the evidence. The heart of plaintiff's Complaint in this connection is contained in the last paragraph of its argument with respect to that exception contained on page 41 of the brief as follows:

> Blue Cross submits that it established its case by a fair preponderance of the evidence and that the Trial Judge improperly applied a more stringent burden of proof, at least with respect to Counts II through V of its Complaint.

As hereinabove indicated, no such thing occurred.

Plaintiff's Exceptions E, F, G and H are nothing more than quarrels with the findings of the trial judge. Exception E contends that the trial judge erred in not finding in Blue Cross's favor with respect to Count 1 in fraud and deceit. Exception F asserts that the trial judge erred in failing to find in Blue Cross's favor with respect to Count 2 for negligent misrepresentation, and Exception G argues that the trial judge erred in failing to find for plaintiff on Count 2 of its Complaint because of circumstances amounting to a mutual mistake of fact. Exception H contends that the trial judge erred in failing to find in plaintiff's favor on Count 4 of its Complaint for unjust enrichment. While it is natural that plaintiff should be disappointed in the findings of the

Court, a review of the record indicates that ample evidence existed for the findings made by the trial court, and with respect to those findings this Court adopts as its opinion in connection with those exceptions the remarks of the trial court in announcing its nonjury decision as contained in the trial transcript at pages 2644-2672.

Plaintiff's Exception I complains that the trial court erred in failing to find that the individual defendants are not third party beneficiaries to the agreements between the Clinic and the Center. Plaintiff is correct in that the Court failed to make such a finding. Such a finding, however, was not required and the Court never reached the question of third party beneficiary status of the individual defendants; nor does there appear to be any reason why such a finding need be made at this time. The trial court further found that plaintiff is liable to the Hospital for reimbursement of conversion-related expenses. If the individual defendants gain anything from that finding, they do so only indirectly, and the question of their status as third party beneficiaries is irrelevant to any issue in the case.

Plaintiff next contended that the trial court erred in failing to find that the defendants failed to exhaust the contractual remedy contained in the agreements between the parties. That argument has been raised repeatedly throughout the history of this litigation. Plaintiff previously contended and now contends that the entire dispute should have been referred to and determined by the resolution process provided in the contracts. The Court can only repeat what has been said in the past with respect to that question—plaintiff did not seek resolution of the matter by the process provided in the contract. Plaintiff sought resolution of the matter in this litigation and, having done so, can hardly be heard to complain that the dispute resolution process contained in the contract was not utilized.

Plaintiff's final exception goes to the trial court's asserted error in failing to limit his decision and his declaratory judgment to the period in which the 1973 and 1976 agreements between the parties were in effect and in refusing to reopen the record for the introduction of the 1979 agreement into evidence. The trial court decided the matter on the basis of the evidence which was

before it. After announcement of the nonjury decision, plaintiff sought to reopen the record to introduce a subsequent agreement between it and the Medical Center. It is not clear what effect that new agreement might have had on the money damages awarded by the Court, but it is clear that the new agreement, assuming its relevancy, in the exercise of due diligence, could have been presented to the Court before the proceedings were concluded and a nonjury decision entered. In *Cargill v. Northwestern Nat. Ins. Co.*, 462 A.2d 833 (Pa. Super. 1983), the Superior Court affirmed the refusal of a trial court to set aside an arbitrators' award where the award had been made on the wrong policy. The Court there pertinently stated:

> The correct policy of insurance was at all times available to [the insurance company] and, in the exercise of due diligence, could have been presented to the arbitrators before the proceedings were concluded and an award entered. Under these circumstances, the trial court correctly refused to set aside the award because appellant had offered in evidence an incorrect policy of insurance.

Both parties refer to some stipulation between them with respect to the 1979 agreement but quarrel as to the result of that stipulation. Suffice it to say that stipulations of the parties like pleadings do not become a part of the record by their mere existence. They must be presented to the Court and read into the record in order to become a part of the evidence in the case. No such thing occurred in the case at bar and nothing further need be said with respect to plaintiff's final exception.

Defendants filed six exceptions to the nonjury decision. In their brief and at argument, they have withdrawn their first exception so nothing need be said with respect thereto. They have further conceded in their brief that exceptions 3 through 6 are not material unless the Court's nonjury decision on the claims presented in the Complaint and in Count 1 of the Counterclaim is altered in some manner. Since no alteration of the nonjury decision is contemplated, the Court will not discuss defendants' exceptions 3 through 6. There remains only defendants' exception No. 2 which contends that the trial judge erred in finding for

the plaintiff on Count 4 of defendants' Counterclaim which had presented a claim for compensatory and punitive damages for tortious interference with a contractual relationship. It is the contention of defendants that the finding is against the weight of the evidence. The Court does not agree and adopts as its opinion with respect to defendants' Exception No. 2 the remarks of the trial court in connection with Count 4 of the Counterclaim contained on page 2673 of the record.

APPENDIX G

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 86-3168 & 86-3191

MONSOUR MEDICAL CENTER, non-profit organization,
Appellant/Cross-Appellee

v.

MARGARET HECKLER, Secretary of the Department of Health and Human Services, and CAROLYNE K. DAVIS, Administrator, Health Care Financing Administration,
Appellees/Cross-Appellants

MONSOUR MEDICAL CENTER,
Appellant

On Appeal from the United States
District Court for the Western
District of Pennsylvania
(D.C. Civ. No. 84-1938)

SUR PETITION FOR REHEARING

Present: GIBBONS, *Chief Judge*, SEITZ, WEIS, HIGGINBOTHAM, SLOVITER, BECKER, STAPLETON, and MANSMANN, *Circuit Judges*.

The petition for rehearing filed by Monsour Medical Center, appellant in the above-entitled case having been submitted to the judges who participated in the decision of this Court and to all the other available circuit judges of the circuit in regular

active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the Court in banc, the petition for rehearing is denied.

BY THE COURT,

/s/ A. LEON HIGGINBOTHAM
Circuit Judge

Dated: January 6, 1987

APPENDIX H

HEALTH INSURANCE FOR THE AGED ACT
42 U.S.C. §1395(h) (1982 & Supp. III)

§1395h. Use of public or private agencies or organizations to facilitate payment to providers of services

(a) Authorization for agreement by Secretary for Implementation; scope of agreement

If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to the provisions of section 1395*oo* of this title and to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers (and to providers assigned to such agency or organization under subsection (e) of this section), and for the making of such payments by such agency or organization to such providers (and to providers assigned to such agency or organization under subsection (e) of this section). Such agreement may also include provision for the agency or organization to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as hospitals, extended care facilities, or home health agencies, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary; (B) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part; and (C) to perform such other functions as are necessary to carry out this subsection.

(b) Prerequisites for agreement or renewal of agreement by Secretary

The Secretary shall not enter into or renew an agreement with any agency or organization under this section unless—

(1) he finds—

(A) after applying the standards, criteria, and procedures developed under subsection (f) of this section, that to do so is consistent with the effective and efficient administration of this part, and

(B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 426 of this title, and the agreement provides for such assistance; and

(2) such agency or organization agrees—

(A) to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section, and

(B) to provide the Secretary with access to all such data, information, and claims processing operations,

as the Secretary may find necessary in performing his functions under this part.

(c) Terms and conditions of agreements

An agreement with any agency or organization under this section may contain such terms and conditions as the Secretary finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under subsection (a) of this section, and shall provide for payment of so much of the cost of administration of the agency or organization as is determined by the Secretary to be necessary

and proper for carrying out the functions covered by the agreement. The Secretary shall provide that in determining the necessary and proper cost of administration, the Secretary shall, with respect to each agreement, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated agency or organization in carrying out the terms of its agreement.

(d) Nomination of agency or organization; withdrawal

If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may, upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, and any provider which has not made a nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Secretary under this section if the Secretary and such agency or organization agree to it.

(e) Assignment or reassignment of provider of services; designation of agency or organization to perform provider services and home health agency functions

(1) Notwithstanding subsections (a) and (d) of this section, the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section if he determines, after applying the standards, criteria, and procedures developed under subsection (f) of this section, that such assignment or reassignment would result in the more effective and efficient administration of this part.

(2) Notwithstanding subsections (a) and (d) of this section, the Secretary may (subject to the provisions of paragraph (4))

designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f) of this section, that such designation would result in more effective and efficient administration of this part.

(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider of services to other than the agency or organization nominated by the provider, he shall furnish (i) the provider and such agency or organization with a full explanation of the reasons for his determination as to the efficiency and effectiveness of the agency or organization to perform the functions required under this part with respect to the provider, and (ii) such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5.

(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judical review in accordance with chapter 7 of title 5.

(4) Notwithstanding subsections (a) and (d) of this section and paragraphs (1), (2), and (3) of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1395x(*o*) of this title) in the region, except that in assigning such agencies to such designated regional agencies or organizations the Secretary shall assign a home health agency which is a subdivision of a hospital (and such

agency and hospital are affiliated or under common control) only if, after applying such criteria relating to administrative efficiency and effectiveness as he shall promulgate, he determines that such assignment would result in the more effective and efficient administration of this subchapter. By not later than July 1, 1987, the Secretary shall limit the number of such regional agencies or organizations to not more than ten.

(5) Notwithstanding any other provision of this subchapter, the Secretary shall designate the agency or organization which has entered into an agreement under this section to perform functions under such an agreement with respect to each hospice program, except that with respect to a hospice program which is a subdivision of a provider of services (and such hospice program and provider of services are under common control) due regard shall be given to the agency or organization which performs the functions under this section for the provider of services.

(f) Development of standards, criteria, and procedures by Secretary for evaluation of agency or organization performance

In order to determine whether the Secretary should enter into, renew, or terminate an agreement under this section with an agency or organization, whether the Secretary should assign or reassign a provider of services to an agency or organization, and whether the Secretary should designate an agency or organization to perform services with respect to a class of providers of services, the Secretary shall develop standards, criteria, and procedures to evaluate such agency's or organization's (1) overall performance of claims processing and other related functions required to be performed by such an agency or organization under an agreement entered into under this section, and (2) performance of such functions with respect to specific providers of services, and the Secretary shall establish standards and criteria with respect to the efficient and effective administration of this part. No agency or organization shall be found under such standards and criteria not to be efficient or effective or to be less efficient or effective solely on the ground that the agency or organization serves only providers located in a single State. Such

standards and criteria shall be published in the Federal Register, and opportunity shall be provided for public comment prior to implementation.

(g) Termination of agreement; procedures applicable

An agreement with the Secretary under this section may be terminated—

(1) by the agency or organization which entered into such agreement at such time and upon such notice to the Secretary, to the public, and to the providers as may be provided in regulations, or

(2) by the Secretary at such time and upon such notice to the agency or organization, to the providers which have nominated it for purposes of this section, and to the public, as may be provided in regulations, but only if he finds after applying the standards, criteria, and procedures developed under subsection (f) of this section and after reasonable notice and opportunity for hearing to the agency or organization, that (A) the agency or organization has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the agency or organization is disadvantageous or is inconsistent with the efficient administration of this part.

(h) Bonding requirement under agreement for officers and employees of agency or organization

An agreement with an agency or organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(i) Liability of certifying and disbursing officers designated under agreement for negligent, etc., payments

(1) No individual designated pursuant to an agreement under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such agency or organization shall be liable to the United States for any payments referred to in paragraph (1) or (2).

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42 U.S.C. §1395*oo*(f) (1982 & Supp. III)

§1395*oo*. Provider Reimbursement Review Board

. . .

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of

services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal to the rate of return on equity capital established by regulation pursuant to section

1395x(v)(1)(B) of this title and in effect at the time the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

Principles of Reasonable Cost Reimbursement

42 C.F.R. §413.17 (1986)
(Formerly Codified at 42 C.F.R. §405.427)

§413.17 Cost to related organizations.

(a) *Principle*. Except as provided in paragraph (d) of this section, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

(b) *Definitions*—(1) *Related to the provider*. Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) *Common ownership*. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

(3) *Control*. Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(c) *Application*. (1) Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to

extend influence, and for other reasons. These goals may be accomplished by means of ownership or control, by financial assistance, by management assistance, and other ways.

(2) If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider may not exceed the market price.

(d) *Exception*. (1) An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the fiscal intermediary (or, if the provider has not nominated a fiscal intermediary, HCFA), that—

(i) The supplying organization is a bona fide separate organization;

(ii) A substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization;

(iii) The services, facilities, or supplies are those that commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and

(iv) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(2) In such cases, the charge by the supplier to the provider for such services, facilities, or supplies is allowable as cost.

Supreme Court, U.S.
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No. 86-1440

In the Supreme Court of the United States

OCTOBER TERM, 1986

MONSOUR MEDICAL CENTER, PETITIONER

v.

OTIS R. BOWEN, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the court of appeals correctly held that the Secretary was not collaterally estopped in federal administrative and judicial Medicare reimbursement proceedings by a prior decision on a similar issue in a state court case, when the state litigation was brought by Blue Cross in its capacity as private insurer, not in its capacity as Medicare "fiscal intermediary," and when the Secretary did not participate in or control the Blue Cross suit.

2. Whether the Secretary's denial of Medicare reimbursement for capital costs associated with the conversion of a private hospital into a non-profit hospital is supported by substantial evidence.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	2
Statement	2
Argument	9
Conclusion	16

TABLE OF AUTHORITIES

Cases:

Albert v. *Lehigh Coal & Navigation Co.*, 431 Pa. 600, 246 A.2d 840 (1968)	13
Bellwood General Hospital v. *Schweiker*, 673 F.2d 1043 (9th Cir. 1982)	16
Chelsea Community Hospital v. *United States*, 2 Cl. Ct. 175 (1983)	15
Chisholm v. *Defense Logistics Agency*, 656 F.2d 42 (3d Cir. 1981)	10
Ethnic Employees of Library of Congress v. *Boorstin*, 751 F.2d 1405 (D.C. Cir. 1985)	12
Goleta Valley Community Hospital v. *Schweiker*, 647 F.2d 894 (9th Cir. 1981)	15
Hospital Affiliates International, Inc. v. *Schweiker*, 543 F. Supp. 1380 (E.D. Tenn. 1982)	15
Hospital Corporation of America v. *FTC*, 807 F.2d 1381 (7th Cir. 1986), cert. denied, No. 86-1492 (May 4, 1987)	10
Marina Mercy Hospital v. *Harris*, 633 F.2d 1301 (9th Cir. 1980)	15
Marrese v. *American Academy of Orthopaedic Surgeons*, 470 U.S. 373 (1985)	11
Medical Center of Independence v. *Harris*, 628 F.2d 1113 (8th Cir. 1980)	15
Montana v. *United States*, 440 U.S. 147 (1979)	8, 11
Pacific Coast Medical Enterprises v. *Harris*, 633 F.2d 123 (9th Cir. 1980)	15
Pollard v. *Cockrell*, 578 F.2d 1002 (5th Cir. 1978)	12

Cases—Continued: Page

Safeguard Mutual Insurance Co. v. *Williams*, 463 Pa. 567, 345 A.2d 664 (1975) 13
Sea-Land Services v. *Gaudet*, 414 U.S. 573 (1974) 12
Shaker Medical Center Hospital v. *Secretary of HHS*, 686 F.2d 1203 (6th Cir. 1982) 16
United States v. *ITT Rayonier, Inc.*, 627 F.2d 996 (9th Cir. 1980) 12, 13, 14
United States v. *Mendoza*, 464 U.S. 154 (1984) 11, 13
United States v. *National Ass'n of Real Estate Boards*, 339 U.S. 485 (1950) 10
University of Tennessee v. *Elliott*, No. 85-588 (July 7, 1986) 10

Statutes and regulations:

28 U.S.C. 1738 11
42 U.S.C. (& Supp. III) 1395 *et seq.* 2
42 U.S.C. (& Supp. III) 1395f(b) 2
42 U.S.C. (& Supp. III) 1395h 5
42 U.S.C. (& Supp. III) 1395x(v)(1)(A) 2
42 U.S.C. (& Supp. III) 1395*oo* 6, 7, 10, 14
42 C.F.R. (1986):
Pt. 405:
Section 405.419(b)(3)(ii) (1985) 15
Sections 405.1801-405.1890 (Subpt. R) 10
Pt. 413:
Section 413.9 2
Section 413.17 (formerly codified at 42 C.F.R. 405.427 (1985)) 3
Section 413.17(b) 15
Section 413.17(b)(2) 3
Section 413.17(b)(3) 3, 15
Section 413.130 2
Section 413.134(g) 3
Section 413.134(g)(3) (formerly codified at 42 C.F.R. 405.415(g)(3) (1985)) 3, 15
Section 413.134(k) 8

Regulations—Continued: Page

Section 413.153(c) (formerly codified at 42 C.F.R. 405.419(c) (1985)) 3, 15
Section 413.153(d)(1)(ii) 8

Pt. 421:

Section 421.100 5

Miscellaneous:

51 Fed. Reg. 34790 (1986) 2
Restatement (Second) of Judgments (1982) 12
18 C. Wright, A. Miller & E. Cooper, *Federal Practice and Procedure* (1981) 12

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BRIEF FOR THE RESPONDENTS IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A1-A21) is reported at 806 F.2d 1185. The opinion of the district court (Pet. App. A22-A34) is reported at [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,083. The opinion of the Provider Reimbursement Review Board (Pet. App. A36-A66) is reported at [1984-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,138.

JURISDICTION

The judgment of the court of appeals was entered on December 5, 1986, and amended on December 18, 1986. A petition for rehearing was denied on January 6, 1987 (Pet. App. A94-A95). The petition for a writ of certiorari was filed on March 6, 1987. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. The Medicare program, 42 U.S.C. (& Supp. III) 1395 *et seq.*, provides federal reimbursement for medical care provided to the aged and disabled. For the years at issue in this case, Medicare reimbursed hospitals for no more than the "reasonable cost" of covered services rendered to Medicare beneficiaries (42 U.S.C. (& Supp. III) 1395f(b), 1395x(v)(1)(A)). "Reasonable cost" is defined to include all necessary and proper costs incurred in rendering services to Medicare patients (42 C.F.R. 413.9 (1986)).[1] Capital-related costs such as interest on indebtedness or depreciation of assets used in patient care are generally considered an element of reasonable cost and may be reimbursed by the Medicare program (42 C.F.R. 413.130 (1986)).

Costs incurred in a transaction between related parties, including interest and depreciation, are subject to special limitations on reimbursement. A health care provider and another party are generally deemed to be "related parties" where there is com-

[1] The opinion below refers to the 1985 edition of the Code of Federal Regulations. Those regulations were redesignated without substantive change in 1986. See 51 Fed. Reg. 34790 (1986). We hereafter refer to both the 1985 and the 1986 codifications where appropriate.

mon ownership or control. Common ownership exists "if an individual or individuals possess significant ownership or equity" in the two organizations (42 C.F.R. 413.17(b)(2) (1986)). Control exists "if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution" (42 C.F.R. 413.17(b)(3) (1986)).

As a general rule, when a health care provider receives goods or services from a related party, reimbursement is limited to the cost of the items to the related party; the price putatively paid by the provider is immaterial (42 C.F.R. 413.17 (1986), formerly codified at 42 C.F.R. 405.427 (1985)). With respect to interest expenses in particular, reimbursement is disallowed if the lender and the provider are related through common ownership, control, or personal relationship (42 C.F.R. 413.153(c) (1986), formerly codified at 42 C.F.R. 405.419(c) (1985)). Similarly, whereas a provider who purchases the assets of an ongoing business in a bona fide arm's-length transaction may take depreciation based on the current value of the purchased assets (42 C.F.R. 413.134(g) (1986)), reimbursable depreciation is more limited where a provider purchases assets from a related party. In a related-party transaction, depreciation expenses must be computed with reference to the *seller's* historical cost basis, minus accumulated depreciation (42 C.F.R. 413.134(g)(3) (1986), formerly codified at 42 C.F.R. 405.415(g)(3) (1985)). The purpose of these regulations is to limit federal reimbursement to reasonable costs that are actually and necessarily incurred by a health care provider, and to screen out artificially inflated cost claims that

may result from dealings between related parties. Pet. App. A9 & n.15.

2. Petitioner, an acute-care hospital, challenges the Secretary's denial of Medicare reimbursement for certain interest and depreciation expenses incurred in connection with its conversion in 1975 from a for-profit corporation to a non-profit corporation. The hospital was established in 1952 by the Monsour Hospital and Clinic, Inc., a Pennsylvania corporation whose stock was 100% owned by members of the Monsour family (Pet. App. A2). In 1975, the Monsour Medical Foundation, which had been established by the Monsour family in 1966, acquired the hospital from the family in a three-step transaction. The Foundation first purchased 3.5% of the family's stock for $500,000. The family members then donated additional stock to the Foundation. Finally, the hospital purchased the family members' remaining shares, via a stock redemption, for $7.5 million. This $7.5 million was represented by a 15-year installment note secured by a mortgage on the hospital's real estate holdings. *Id.* at A2-A3. The Foundation, which thus became the sole stockholder of the Monsour Hospital and Clinic, Inc., reorganized the hospital as a Pennsylvania non-profit corporation and renamed it the Monsour Medical Center, petitioner here.

After the conversion, petitioner sought Medicare reimbursement for the sizeable interest expenses that it incurred on the 1975 mortgage agreement with members of the Monsour family.[2] Petitioner also

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[2] After the first five years, the interest due on the note was pegged to the prime rate (Pet. App. A3). When interest rates rose in the late 1970's, "the hospital's monthly interest obligation under this note at various times doubled or even

sought reimbursement for depreciation on the acquired hospital assets, using a stepped-up basis derived from the 1975 sale rather than the private corporation's original cost basis. Petitioner initially received reimbursement for those costs through Blue Cross of Western Pennsylvania (Blue Cross), which, under contract with respondent Secretary, acted as the "fiscal intermediary" that reviewed and paid claims for Medicare reimbursement (42 U.S.C. (& Supp. III) 1395h; 42 C.F.R. 421.100 (1986)). See Pet. App. A4 & n.6. Blue Cross not only acted as a Medicare intermediary but also operated its own private health insurance program. In 1981, Blue Cross determined that the interest costs and higher depreciation expenses associated with the hospital's conversion were not reimbursable under its insurance program, because the conversion had been effected by related parties, not through an arm's-length transaction. The Secretary reached the same conclusion under the Medicare program. *Id.* at A4. Blue Cross subsequently disallowed claims for the costs in question.

In 1983, Blue Cross, "acting in its capacity as a private insurer" (Appellant's Br. 6), sued petitioner in Pennsylvania state court. Blue Cross sought, among other things, a declaratory judgment that the claimed capital-related costs of petitioner's conversion to non-profit status were not reimbursable. Petitioner counter-claimed for a contrary declaratory judgment. In 1983 the state court concluded that the conversion had occurred between unrelated parties and therefore

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tripled from the amounts it had previously been paying" (*id.* at A3 n.5). The hospital eventually encountered financial difficulties and was forced into bankruptcy (Pet. 6).

held that the interest and depreciation costs were reimbursable. See Pet. App. A5-A6, A69-A85, A86-A93. The state court reasoned: "It was never intended that control of the hospital continue in the Monsours subsequent to the conversion nor has such control continued in fact" (*id.* at A82). The Superior Court of Pennsylvania subsequently affirmed the trial court's decision (*id.* at A67-A68).

3. In 1983, petitioner challenged the Secretary's determination that the 1975 sale had been effected between related parties for purposes of the Medicare program.[3] Petitioner accordingly filed an appeal, pursuant to 42 U.S.C. (& Supp. III) 1395*oo*, with the Provider Reimbursement Review Board (PRRB or Board), an administrative tribunal empowered to review certain reimbursement determinations made by a Medicare fiscal intermediary. The Board concluded that the trustees of the Foundation that approved the acquisition of the hospital (all of whom were appointed by the Monsours) and the stockholders selling the hospital (the Monsours) were "related parties" within the meaning of the Medicare regulations. Pet. App. A54, A63-A64. The Board pointed out that the 1975 transaction was one "involving the sale of a for-profit hospital corporation's stock whereby the stockholders st[ood] to make a sizeable financial gain," and hence that the relatedness of the Monsours and the Foundation trustees whom they appointed must be judged by the rules that pertain in an ordinary commercial setting (*id.* at A64). The Board accordingly concluded that the Foundation

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[3] Petitioner challenged not only the interest and depreciation determinations but several other reimbursement decisions as well. Only the interest and depreciation claims are at issue in this Court. See Pet. App. A36-A37; Pet. 3 & n.3.

trustees acted as "surrogates of the [Monsour] Family" in approving the sale and that they had merely implemented a long-term plan that the Foundation had previously adopted when it was still formally controlled by the Monsour family (*id.* at A63). The Board's decision upholding Blue Cross's disallowance became final when the Secretary declined to review it. 42 U.S.C. (& Supp. III) 1395*oo*.

Petitioner challenged that decision in the United States District Court for the Western District of Pennsylvania. As a threshold matter, the court rejected petitioner's argument that the state court ruling against Blue Cross collaterally estopped the Secretary from litigating the "relatedness" issue under the Medicare program. Noting that, although Blue Cross and the Secretary had similar interests, there was no evidence that the Secretary directed or participated in the state court litigation (Pet. App. A27), the court found that the Secretary was neither a party nor in privity with Blue Cross in the state litigation. The court also questioned whether the Secretary could even have participated in the state court action without first exhausting the statutory review procedures set out in the Medicare statute (*ibid.*).

Turning to the merits, the court acknowledged that the issue before it (whether substantial evidence supported the Secretary's conclusion that the Monsours and the Foundation trustees were related parties) differed from the issue in the state litigation (whether Blue Cross established by a preponderance of the evidence that those persons were related parties). Pet. App. A28. Nevertheless, the district court, like the state court, ruled in favor of petitioner. The district court focused, as the state court had done (see *id.* at A5 n.9), on whether the Monsour family continued to control petitioner *after* the 1975 sale, and it

found no substantial evidence of such control in the record (*id.* at A31). The court consequently remanded the case to the Board with instructions to reimburse petitioner for the interest and depreciation costs (*id.* at A34).

4. The court of appeals unanimously reversed, holding that substantial evidence supported the Secretary's determination. The court first agreed that the state court decision against Blue Cross did not collaterally estop the Secretary from litigating the Medicare issue. After noting that the Secretary was obviously not a party to the state litigation, the court concluded that because the government did not exercise control over Blue Cross's conduct of the state court suit, it could not be estopped by that suit (Pet. App. A16, citing *Montana* v. *United States*, 440 U.S. 147 (1979)). The court pointed out that the Secretary had not required the suit to be filed, reviewed the complaint, paid attorneys' fees or costs, directed an appeal, appeared as amicus, or otherwise exercised control over the Blue Cross litigation (Pet. App. A16).

On the merits, the court of appeals upheld the Secretary's determination that the 1975 sale had occurred between related parties.[4] The court rejected the dis-

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[4] The PRRB, as an alternative basis for its decision, had ruled that the conversion involved the acquisition by the Foundation of stock rather than assets, and hence that interest and additional depreciation expenses arising out of the transaction were not reimbursable (Pet. App. A64-A65). See 42 C.F.R. 413.153(d)(1)(ii), 413.134(k) (1986). The district court concluded that this alternative holding was erroneous because the parties had stipulated before the Board that the stock-versus-asset question was not in dispute (Pet. App. A31). The court of appeals found no need to address the correctness of the district court's ruling in this respect, because it found the Board's related-parties holding to be supported by substantial evidence (*id.* at A13-A14 n.23).

trict court's focus on the parties' course of conduct during the years after the transaction was completed (Pet. App. A13-A15). Rather, the court of appeals held that a reasonable interpretation of the related-party regulations required an inquiry into the parties' status at the time of the sale, viz., in May 1975 (*id.* at A11-A13 & n.20). The court then concluded that the Board's determination that the parties were related at the time of the hospital conversion was supported by substantial evidence:

> Virtually all the factual evidence in the record before the PRRB establishes that the creation of the Foundation, the selection of its board members and trustees, and the financial transactions that effectuated the hospital conversion all proceeded according to the plans of, and were executed by, the members of the Monsour family who were the hospital's original (and only) stockholders.

Id. at A14. The court accordingly found "unequivocally" that the Secretary's decision was supported by substantial evidence (*id.* at A13).

ARGUMENT

The court of appeals' fact-specific decision is correct and is not in conflict with any decision of this Court or of any other court of appeals. Petitioner has not demonstrated that the issue it raises is of any general importance, and further review is unwarranted.

1. Petitioner first contends (Pet. 11-18) that the Pennsylvania court decision against Blue Cross collaterally estops the Secretary from establishing that the 1975 sale was effected between related parties. Petitioner points to no decision that holds, contrary to the court of appeals' decision here, that a ruling

against a Medicare fiscal intermediary, let alone one against the intermediary only in its distinct capacity as a private insurer, can have preclusive effect in any subsequent proceeding against the federal government. Moreover, although petitioner of necessity is arguing that the PRRB, and not just the courts below, erred in not holding the Secretary estopped on the related-party issue (see Pet. 11, 17),[5] petitioner identifies no decision of this Court that, without reference to specific statutes or regulations, requires administrative agencies to apply general preclusion law. Compare *University of Tennessee* v. *Elliott*, No. 85-588 (July 7, 1986) (administrative decisions may have preclusive effect in later court proceedings); *Chisholm* v. *Defense Logistics Agency*, 656 F.2d 42, 46 (3d Cir. 1981) (agency *permitted* to adopt preclusion principles). And petitioner points to no statute, decision, or regulation applicable to the PRRB in particular that requires it to apply preclusion principles (see generally 42 U.S.C. (& Supp. III) 1395*oo*; 42 C.F.R. Pt. 405, Subpt. R (1986)). In any event, even if one

[5] If petitioner is arguing only that the lower courts should have applied preclusion principles, preclusion was clearly improper because the issue in the federal suit was not the same as the issue in the state court suit. The federal courts had to decide whether the Board's decision was supported by substantial evidence; the state courts had to decide whether Blue Cross established relatedness by a preponderance of the evidence or, perhaps, simply whether the parties to the conversion were in fact related. See Pet. App. A28; *United States* v. *National Ass'n of Real Estate Boards*, 339 U.S. 485 (1950) (failure to meet higher burden of proof does not preclude attempt to meet lower burden); *Hospital Corporation of America* v. *FTC*, 807 F.2d 1381, 1384-1385 (7th Cir. 1986), cert. denied, No. 86-1492 (May 4, 1987) (substantial evidence review more deferential than independent inquiry into facts found by agency).

assumes that the Board was obligated to apply general preclusion principles, the court of appeals' decision is correct.

A judicial decision on an issue precludes relitigation of the same issue only by parties to the suit and certain non-parties often described as "privies." See *Montana* v. *United States*, 440 U.S. at 153-154.[6] This Court held in *Montana* that the United States was in privity with a party "whose litigation had been totally financed and controlled by the Federal Government" (*United States* v. *Mendoza*, 464 U.S. 154, 159 n.5, 164 n.9 (1984)). Here, the Secretary obviously was not a party to the state court suit against Blue Cross. Nor did the Secretary exercise control over or finance the state court suit: indeed, as the court of appeals explained (Pet. App. A16), none of the indicia of control identified by this Court in *Montana* is present in this case. Petitioner does not contest these facts or point to any decision of this Court other than *Mon-*

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[6] In *Montana*, this Court applied federal common law preclusion principles, rather than state preclusion law, in determining whether, as here, the federal government could be collaterally estopped by a state court suit. 440 U.S. at 153-155. The court of appeals in this case likewise applied federal law; and petitioner, although it mentions the issue (Pet. 12 n.6), does not challenge the court of appeals' approach in the petition (see Pet. i (Questions Presented)). We accordingly assume that federal law governs here.

We note that the full faith and credit statute, 28 U.S.C. 1738, which presumptively requires application of Pennsylvania preclusion law to determine the effect in a "court" of a Pennsylvania court decision (*Marrese* v. *American Academy of Orthopaedic Surgeons*, 470 U.S. 373 (1985)), by its terms does not require an administrative agency like the PRRB to apply state preclusion law. In any event, as noted below (note 7, *infra*), Pennsylvania preclusion principles would lead to the same result as federal principles.

tana in which the federal government has been held subject to non-party preclusion.

Lacking support in this Court's precedent, petitioner suggests that the government is collaterally estopped here on the theory that its interests were identical to those of Blue Cross (Pet. 15) and therefore "were sufficiently represented by a similarly-situated party in [the] prior proceeding" (*id.* at 14, 15). This suggestion misunderstands the doctrine of "representation" under which non-party preclusion has been permitted. The doctrine requires more than mere coincidence of interests; it requires that the party have actually represented the non-party's interests and, by virtue of actual control or legal obligation (perhaps inherent in a special relationship like that between family members), that the party have been legally accountable for representing the non-party's interests. See *United States* v. *ITT Rayonier, Inc.*, 627 F.2d 996, 1003 (9th Cir. 1980) ("virtual representative" doctrine "contemplates an express or implied legal relationship by which parties to the first suit are accountable to non-parties * * * [in] a subsequent suit with identical issues"); *Sea-Land Services* v. *Gaudet*, 414 U.S. 573, 593 (1974) (non-party may be collaterally estopped where litigating party acts in a fiduciary capacity); *Ethnic Employees of Library of Congress* v. *Boorstin*, 751 F.2d 1405, 1410-1411 & n.8 (D.C. Cir. 1985); *Pollard* v. *Cockrell*, 578 F.2d 1002, 1008-1009 (5th Cir. 1978); see generally 18 C. Wright, A. Miller & E. Cooper, *Federal Practice and Procedure* § 4457 (1981); Restatement (Second) of Judgments § 41 (1982). Even petitioner acknowledges that Blue Cross had no legal obligation to act as the Secretary's representative in the state court suit and did not in fact do so. Blue Cross litigated that

suit, as petitioner stated in the court of appeals, "in its capacity as a private insurer" (Appellant's Br. 6).[7]

In addition, application of the doctrine of representation to the government, even if one assumes arguendo that it could ever be appropriate,[8] would be

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[7] Under Pennsylvania rules of preclusion, which require "privity" for non-party preclusion (*Safeguard Mutual Insurance Co.* v. *Williams*, 463 Pa. 567, 574, 345 A.2d 664, 668 (1975)), the Secretary would likewise not be bound by the ruling against Blue Cross. The Secretary did not have the required "full and fair opportunity to litigate the issue" in the state court suit (*ibid.*). Moreover, "[t]o be concluded by a prior decree or judgment one must be a party to the action, or what is equivalent thereto with a right to control the proceedings and take an appeal." *Albert* v. *Lehigh Coal & Navigation Co.*, 431 Pa. 600, 612, 246 A.2d 840, 846 (1968). The court of appeals found no basis for concluding that the United States had control over Blue Cross's state court litigation, and petitioner advances no reason for overturning that fact-bound determination.

[8] In *United States* v. *Mendoza*, *supra*, this Court held that a decision against the federal government in one suit could not be invoked by a person not a party to that suit to estop the government collaterally in a later suit. For reasons similar to those relied on by the Court in *Mendoza*, we question whether non-party preclusion should ever be invoked against the government in the absence of actual control by the government of the first proceeding. The government's interests in the resolution of legal issues are too extensive and consequential, and subject to too many distinctive considerations (see 464 U.S. at 159-163), to permit the government to be bound by litigation decisions that it has not itself made.

In *United States* v. *ITT Rayonier, Inc.*, *supra*, relied on by petitioner (Pet. 13), the Ninth Circuit held that the United States was precluded from raising an issue litigated by a state agency. We question the correctness of that decision. In any event, the decision turned on a highly fact-specific analysis of the relationship between the state agency's authortiy to enforce a pollution discharge permit and the closely

plainly inappropriate in this case. The Medicare statute establishes a detailed set of procedures for obtaining administrative and federal court review of Medicare reimbursement determinations, procedures that give due regard to agency expertise in the administration of the Medicare program. See 42 U.S.C. (& Supp. III) 1395*oo*. Petitioner's argument would permit those carefully crafted procedures to be circumvented by litigating private insurance reimbursement issues in state court and then asserting that the state court determinations have collateral estoppel effect on federal review of similar issues arising in the Medicare program. As the district court said in rejecting petitioner's collateral estoppel claim, "[s]erious questions remain concerning whether Medicare could have participated in the state court hearing without exhausting federal procedures under the Social Security Act" (Pet. App. A27).

2. Petitioner also contends (Pet. 18-22) that the court of appeals erred in concluding that substantial

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related authority of the Environmental Protection Agency (EPA) to enforce the same permit. The first proceeding was an enforcement action brought by the state agency in the exercise of federally granted and revocable permit-enforcement power, and the action was brought only after "the EPA's prompting that absent state action [the defendant] was a candidate for federal enforcement" (627 F.2d at 1003). The second proceeding was an EPA action to enforce the same permit, and that action, though it could have been filed at any time, was not filed until after an initial adverse state court ruling (*id.* at 999). Of course, the statutory scheme at issue in *ITT Rayonier* is not at issue here. Moreover, Blue Cross was litigating its private insurance interests in its state court suit, not the Secretary's interests; and this case does not involve a government-initiated suit, let alone one that could have been filed earlier but was in fact initiated only after a setback in earlier, government-prompted litigation.

evidence supported the PRRB's finding that the 1975 sale of the hospital was effected between related parties. This contention is fact-specific and is without merit. The court of appeals properly deferred to the Secretary's patently reasonable interpretation of his related-party regulations (42 C.F.R. 413.17(b), 413.153(c), 413.134(g)(3) (1986)) as focusing on the Monsours' power to control or influence the Foundation at the time of the sale (Pet. App. A10-A15). This focus on the relationship that exists at the time of the challenged transaction is wholly consistent with the rulings of other courts on this issue, including the decisions cited by petitioner (Pet. 19). See, *e.g.*, *Medical Center of Independence* v. *Harris*, 628 F.2d 1113, 1116-1119 (8th Cir. 1980); *Goleta Valley Community Hospital* v. *Schweiker*, 647 F.2d 894, 896-897 (9th Cir. 1981); *Hospital Affiliates International, Inc.* v. *Schweiker*, 543 F. Supp. 1380, 1386-1387 (E.D. Tenn. 1982); cf. *Pacific Coast Medical Enterprises* v. *Harris*, 633 F.2d 123, 134 (9th Cir. 1980) (related-party regulation does not apply to acquisition of assets where parties were engaged in arm's-length dealings at the time of the acquisition). Contrary to petitioner's suggestion (Pet. 19), moreover, factors like majority ownership and day-to-day operating control are not the sole indicators of a transaction between related parties. Relatedness may stem from "personal" as well as juridical relationships (42 C.F.R. 405.419(b)(3)(ii) (1985)), and the relationship need only be close enough so that one party has "the power, directly or indirectly, significantly to influence" the actions of the other. See 42 C.F.R. 413.17(b)(3) (1986); *Chelsea Community Hospital* v. *United States*, 2 Cl. Ct. 175, 181 (1983); *Marina Mercy Hospital* v. *Harris*, 633 F.2d 1301, 1303 (9th Cir. 1980).

Finally, petitioner is wrong in asserting (Pet. 20) that the court of appeals refused to consider evidence post-dating the 1975 sale and affirmed the Board's finding simply because the conversion went as the Monsours had planned it. The court of appeals specifically declined to rely on the simple "syllogism" that petitioner challenges (Pet. App. A13 n.22). The court merely held that, in the circumstances surrounding the particular transaction at issue here, including the facts that the Monsours created the Foundation, appointed all of its trustees, and planned the conversion, there was "powerful and substantial evidence of the Monsours' continuing power to influence the Foundation at the time in question" (*id.* at A15). The court of appeals' ruling is not in conflict with decisions indicating that all the circumstances surrounding the transaction are relevant to the relatedness inquiry (see, *e.g.*, *Shaker Medical Center Hospital* v. *Secretary of HHS*, 686 F.2d 1203 (6th Cir. 1982); *Bellwood General Hospital* v. *Schweiker*, 673 F.2d 1043 (9th Cir. 1982)).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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v.

OTIS R. BOWEN, M.D., Secretary of the United States Department of Health and Human Services, and WILLIAM L. ROPER, M.D., Administrator, Health Care Financing Administration,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

---

~~MOTION FOR LEAVE TO FILE BRIEF~~
AND BRIEF OF NATIONAL ASSOCIATION FOR HOME CARE, AMERICAN HOSPITAL ASSOCIATION, AND AMERICAN HEALTH CARE ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

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MOTION FOR LEAVE TO FILE BRIEF OF NATIONAL ASSOCIATION FOR HOME CARE, AMERICAN HOSPITAL ASSOCIATION, AND AMERICAN HEALTH CARE ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

Pursuant to Rule 36 of the Rules of this Court, the *amici curiae* seek leave to file the attached *amicus* brief in support of the petition for certiorari filed by Monsour Medical Center.[1]

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[1] Pursuant to Rule 36.1 of this Court, consent to the filing of this brief has been granted by both parties. The letters of consent have been lodged with the Clerk of the Court.

The National Association for Home Care ("NAHC") is a membership association representing over 4,000 home health agencies throughout the United States. NAHC advances the interests of home health care before the United States Congress, the courts, and federal administrative agencies. Since the major source of funding for home health care is Medicare, NAHC has dedicated a substantial proportion of its resources to assisting its members in their relations with the Health Care Financing Administration ("HCFA") and its fiscal intermediaries. NAHC has worked strenuously to develop consistent and reliable decisionmaking by the fiscal intermediaries and has encouraged strict oversight of intermediary operations by HCFA.

The role of private insurance as a payment source for home health care is growing. Many of the Medicare intermediaries, Aetna and Blue Cross, for example, are offering or developing home health care insurance as a supplement to Medicare. With these private plans, the intermediaries are structuring coverage rules and reimbursement systems along Medicare lines. Inconsistency between Medicare and private insurance regarding the proper interpretation of rules would have a dramatic effect on the efficient and effective delivery of home health care services.

The American Hospital Association ("AHA") is the primary organization of hospitals in the United States. It is a not-for-profit membership corporation organized under the laws of the State of Illinois. The principal corporate objective of the AHA is to promote high-quality health care and health care services for all people through leadership in the development of public policy, leadership in the representation and advocacy of hospital and health care organization interests, and leadership in the provision of services to assist hospitals and health care organizations in meeting the health care needs of their communities. Its membership includes

approximately 6,000 hospitals and other health care institutions, as well as approximately 35,000 individuals.

The overwhelming majority of AHA's institutional members provide health care services to Medicare patients and, accordingly, are vitally concerned with sound government policies, procedures, and requirements pertaining to the administration and operation of the Medicare program.

The AHA has no parent or non-wholly-owned subsidiary companies. Its only affiliate is the Hospital Research and Educational Trust.

The American Health Care Association ("AHCA") is the nation's largest federation of licensed nursing homes and allied long term care facilities. AHCA has 50 affiliated state associations and a District of Columbia affiliate, together representing nearly 9,000 individual facility members continuously providing nursing care and related services to approximately 900,000 elderly, convalescent and chronically ill residents. AHCA and its affiliates are non-profit associations. A majority of the nation's long term health care facilities belong to AHCA and its affiliates.

AHCA was founded in 1949 to promote standards for professionals in long term health care delivery, and quality care for residents in a safe environment and at fair payment for services. AHCA represents its members' concerns on Capitol Hill and before the federal agencies. The association assists Members of Congress and regulators in developing the policies that govern one of America's most highly regulated service sectors. One of the biggest challenges AHCA addresses is ensuring that long term care facilities have financial resources to guarantee the highest level of care delivery. Because the nursing home care provided by AHCA members is supported in part by Medicare, AHCA and its members

have a strong interest in the fair and consistent administration of that program.

The decision of the United States Court of Appeals for the Third Circuit will have potentially significant and adverse impact on the members of NAHC, AHA, and AHCA and on health care providers generally. By refusing to give collateral estoppel effect to the state court judgment, the court of appeals acted contrary to the reasonable expectations of any health care provider, and this precedent could multiply litigation for providers and leave them subject to contradictory rulings by different courts on identical issues.

CONCLUSION

For the foregoing reasons, the Court should grant leave to file the attached brief *amicus curiae*.

Respectfully submitted,

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Dated: May 4, 1987

TABLE OF CONTENTS

Page

MOTION FOR LEAVE TO FILE BRIEF OF NATIONAL ASSOCIATION FOR HOME CARE, AMERICAN HOSPITAL ASSOCIATION, AND AMERICAN HEALTH CARE ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI i

TABLE OF AUTHORITIES vi

STATEMENT OF INTEREST 1

STATEMENT OF THE CASE 2

REASONS FOR GRANTING THE WRIT 2

1. The Court Of Appeals Misapprehended The Relationship Among Medicare, Its Intermediaries, And Health Care Providers 2

2. The Third Circuit's Decision Will Incite Unnecessary Litigation For Health Care Providers And Other Parties 4

CONCLUSION 7

TABLE OF AUTHORITIES

CASES: Page

Allen v. McCurry, 449 U.S. 90 (1980) 5-6

Blonder-Tongue Laboratories, Inc. v. University of Illinois Foundation, 402 U.S. 313 (1971) 6

Frankford Hospital v. Blue Cross of Greater Philadelphia, 417 F. Supp. 1104 (E.D. Pa. 1976), *aff'd*, 554 F.2d 1253 (3d Cir.), *cert. denied*, 434 U.S. 860 (1977) 3

St. John's McNamara Hospital Organization v. The Associated Hospital Service, Inc., 410 F. Supp. 67 (D.S.D.), *rev'd mem.*, 538 F.2d 333 (8th Cir. 1976) 3

STATUTES AND REGULATIONS:

42 C.F.R. § 421.3 (1986) 2

42 C.F.R. § 421.5(b) (1986) 3

42 C.F.R. § 421.100(b) (1986) 2

42 C.F.R. § 421.100(c) (1986) 2

MISCELLANEOUS:

Comments of Justice Scalia before the American Bar Association, *ABA Journal*, Apr. 1, 1987, at 20 4

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BRIEF OF NATIONAL ASSOCIATION FOR HOME CARE, AMERICAN HOSPITAL ASSOCIATION, AND AMERICAN HEALTH CARE ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

STATEMENT OF INTEREST

The interest of the *amici* is set forth in the foregoing Motion for Leave to File Brief as *Amici Curiae*, which is hereby incorporated by reference.

STATEMENT OF THE CASE

The *amici* incorporate by reference the statement of the case set forth in the Petition for a Writ of Certiorari of Monsour Medical Center.

REASONS FOR GRANTING THE WRIT

The *amici* support Monsour Medical Center's Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit. The Third Circuit's decision in this case, if left unreviewed, will create serious problems for the health care industry, and beyond. The Third Circuit's decision represents an erroneous view of the relationships among Medicare, fiscal intermediaries and health care providers. Because the Third Circuit failed to take account of these relationships, its ruling will injure health care providers and undermine the critical judicial policies supporting collateral estoppel.

1. The Court of Appeals Misapprehended the Relationship Among Medicare, Its Intermediaries, and Health Care Providers

The Third Circuit's decision reflects a basic misunderstanding of the relationship between Medicare and its fiscal intermediaries. For any provider, the fiscal intermediary *is* Medicare. Each intermediary has contracted with the Secretary of Health and Human Services (HHS) to determine and make Medicare payments to health care providers. 42 C.F.R. § 421.3(1986). Under the Medicare regulations, "[t]he intermediary must receive, disburse and account for funds in making Medicare payments." 42 C.F.R. § 421.100(b) (1986). In addition, it "must audit the records of providers of services." 42 C.F.R. § 421.100(c) (1986). Until terminated by the Secretary, the intermediary has sole responsibility for making Medicare payments and conducting audits. Since the intermediary is acting on behalf of the Secretary in carrying out these responsibilities, its contract with the Secretary

provides for indemnification by the federal government with respect to any actions taken on behalf of the Secretary. 42 C.F.R. § 421.5(b) (1986).

The Third Circuit also misunderstood the close ties created by fiscal intermediaries between the Medicare program and private health insurance. Many providers of health care have private insurance contracts with their fiscal intermediaries that, like the contract between Monsour Medical Center and Blue Cross of Western Pennsylvania, incorporate Medicare's cost reimbursement regulations. *Cf. Frankford Hospital v. Blue Cross of Greater Philadelphia*, 417 F. Supp. 1104, 1106 (E.D. Pa. 1976), *aff'd*, 554 F.2d 1253 (3d Cir.), *cert. denied*, 434 U.S. 860 (1977); *St. John's McNamara Hospital Organization v. The Associated Hospital Service, Inc.*, 410 F. Supp. 67, 82 (D.S.D.), *rev'd mem.*, 538 F.2d 333 (8th Cir. 1976) (noting as a factual matter that the ultimate resolution of dispute between hospital and Blue Cross Association, as fiscal intermediary, "may well affect the reimbursement formula used by [Blue Cross Association] in its dealings as a private insurer with plaintiff and with other hospitals").

These contract provisions represent the choice of fiscal intermediaries to administer their private health care programs under unitary and certain standards that are applicable to both Medicare and private insurance. The Medicare program directly benefits from this coordinated approach, moreover, since fiscal intermediaries can jointly administer their public and private insurance business and avoid expensive duplication of functions. Indeed, that is precisely what the fiscal intermediary in this case, Blue Cross of Western Pennsylvania, did.

In refusing to apply collateral estoppel in this case, the court of appeals ignored these many ties between Medicare and the intermediary/private insurer. The combination of private insurance functions with inter-

mediary responsibilities is possible only because both Medicare and the private insurers have precisely the same interests and policies in reimbursement issues. Because of this identity between the intermediary as insurer and the intermediary as intermediary, collateral estoppel is especially appropriate in this case.

2. The Third Circuit's Decision Will Incite Unnecessary Litigation For Health Care Providers And Other Parties

The potential effect of the Third Circuit's decision is not confined to the Monsour Medical Center, or to Medicare's related parties regulation. The direct effect of the Third Circuit's decision will be to increase the likelihood of litigation over cost reimbursement issues whenever the same question applies both to Medicare and to private insurer reimbursement—which often is true. This additional litigation, as in this case, may involve the application of the identical law to the identical transaction. The dangers of inconsistent pronouncements, as in this case, always will be present, along with the burdens on health care providers of more lawsuits.[1]

Health care providers, moreover, will be caught in a squeeze. Providers are dependent on reimbursement from both private insurers and Medicare. When anticipating business costs for which the provider will need reimbursement, the provider will try to meet the requirements of all applicable reimbursement standards. After the Third

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[1] The Third Circuit's decision comes at a time when the federal and state court systems are facing ever-increasing caseloads. Since 1960, for example, the number of civil cases filed in United States District Court every year has risen from approximately 58,000 to approximately 250,000. *See* Comments of Justice Scalia before the American Bar Association, as quoted in *ABA Journal*, Apr. 1, 1987, at 20.

The systemic costs of the Third Circuit's decision provide an additional reason for this Court to grant review—and to adopt a more pragmatic approach to collateral estoppel.

Circuit's ruling, however, there can be no certainty for the provider. If the fiscal intermediary in its private capacity wins a judgment in state court, that judgment will estop the hospital in a proceeding before the Provider Reimbursement Review Board (PRRB). If the fiscal intermediary loses in the private insurance context, however, the Secretary still can ignore the decision, leaving the provider to seek redetermination before the PRRB of the identical issue. Similarly, if the intermediary's ruling is tested first before the PRRB and the provider prevails, the intermediary in its private capacity is free to disregard that ruling. This heightened likelihood of inconsistent answers to the identical question greatly increases the difficulty of planning for any business.

The decision by fiscal intermediaries to administer their private health care programs under the same standard applicable to Medicare involved a balancing of benefits and burdens. Health care providers benefit from the application of a unitary and certain standard, and both providers and the intermediaries bear the risk that some reimbursement questions will be decided adversely to their interests. The Third Circuit's decision upsets this balance of benefits and burdens. By denying collateral estoppel when the provider wins the first action, even though collateral estoppel will apply when the provider loses in the first action, the Third Circuit has imposed the entire burden of uncertainty on providers. This is especially damaging because most providers are at a disadvantage in negotiating with third-party payors over contract terms, which are determined by uniform agreements that are characteristically offered on a take-it-or-leave-it basis.

The Third Circuit's decision also undermines the rule of law by its failure to address any of the interrelated policies behind collateral estoppel. Collateral estoppel seeks to "relieve parties of the cost and vexation of multiple lawsuits, conserve judicial resources, and by pre-

venting inconsistent decisions, encourage reliance on adjudication." *Allen v. McCurry*, 449 U.S. 90, 94 (1980). The prevention of inconsistent decisions is a key facet of the rule of law. This Court gave great weight to the need to preserve the rule of law when it abandoned the mutuality requirement for collateral estoppel in *Blonder-Tongue Laboratories, Inc. v. University of Illinois Foundation*, 402 U.S. 313 (1971). The ~~Court~~ stated:

> Authorities differ on whether the public interest in efficient judicial administration is a sufficient ground in and of itself for abandoning mutuality, but it is clear that more than crowded dockets is involved. The broader question is whether it is any longer tenable to afford a litigant more than one full and fair opportunity for judicial resolution of the same issue. The question in these terms includes as a part of the calculus the effect on judicial administration, but it also encompasses the concern exemplified by Bentham's reference to the gaming table in his attack on the principle of mutuality of estoppel.

Id. at 328-329 (footnote omitted).

When a court has directly passed on a question that has been fully and fairly litigated, the only object of relitigating the same issue is to gamble on achieving an outcome in conflict with the first judgment. Otherwise, the relitigation serves no purpose at all. Relitigation in pursuit of directly inconsistent decisions, however, is exactly the sort of relitigation that collateral estoppel seeks to prevent. When a second tribunal reaches a conflicting result on the same issue, it undermines the rule of law and destroys reliance on adjudication.

CONCLUSION

For the foregoing reasons, the *amici* respectfully urge that the Monsour Medical Center's petition for a writ of certiorari be granted.

Respectfully submitted,

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TABLE OF AUTHORITIES

Cases:	Page
Allen v. McCurry, 449 U.S. 90 (1980)	5
Chisholm v. Defense Logistics Agency, 656 F.2d 42 (3d Cir. 1981)	4
Ethnic Employees of the Library of Congress v. Boorstin, 751 F.2d 1405 (D.C. Cir. 1985)	3
Graybill v. United States Postal Serv., 782 F.2d 1567 (Fed. Cir.), *cert. denied*, 107 S. Ct. 462 (1986)	4
Kremer v. Chemical Constr. Corp., 456 U.S. 461 (1982)	4
Montana v. United States, 440 U.S. 147 (1979)	2
Safir v. Gibson, 432 F.2d 137 (2d Cir.), *cert. denied*, 400 U.S. 942 (1970)	5
Sea-Land Services, Inc. v. Gaudet, 414 U.S. 573 (1974)	3
United States v. ITT Rayonier, Inc., 627 F.2d 996 (9th Cir. 1980)	1, 2
United States v. Stauffer Chemical Co., 464 U.S. 165 (1984)	3
University of Tennessee v. Elliott, 106 S. Ct. 3220 (1986)	2, 4, 5
Statutes and Regulations:	
5 U.S.C. §706 (1982)	5
28 U.S.C. §1738 (1982)	5
42 U.S.C. §1395*oo* (1982 & Supp. III)	4
42 U.S.C. §2000e-5(b) (1982)	4
42 C.F.R. §§405.1801 to 405.1890 (1986)	4
Miscellaneous:	
Provider Reimbursement Manual §1004.3	5

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REPLY BRIEF FOR THE PETITIONER

1. The decision of the Ninth Circuit in *United States v. ITT Rayonier, Inc.*, 627 F.2d 996 (9th Cir. 1980), is not consistent with the Third Circuit's decision in this case. In *ITT Rayonier* the Ninth Circuit held that the United States was collaterally estopped by a state court judgment against the Washington State Department of Ecology (DOE). Although the Solicitor General explicitly "question[s] the correctness of that decision," Respondents' Brief at 13 n.8, the Solicitor argues that

there is no tension between *ITT Rayonier* and the Third Circuit's decision in this case because the only question at issue here is whether a judgment against a Medicare fiscal intermediary can have preclusive effect in a proceeding before the Provider Reimbursement Review Board (PRRB). Nothing justifies so narrow a definition of the question in this case. Contrary to the Solicitor's characterization, the statutory scheme in *ITT Rayonier* did not mandate the application of preclusion principles. The Ninth Circuit relied instead on the general policies underlying collateral estoppel.

2. The Solicitor General, like the Third Circuit, assumes that nonparty estoppel is available only in the precise factual circumstances of *Montana v. United States*, 440 U.S. 147 (1979). *Montana*, however, did not announce a unique and fact-bound rule but rather articulated general principles for nonparty collateral estoppel. One major concern emphasized in *Montana* was the need to avoid inconsistent rulings, a consideration that is heightened when a federal court totally ignores a state-court judgment. *See University of Tennessee v. Elliott*, 106 S. Ct. 3220, 3226-3227 (1986). But the Solicitor's brief completely disregards the injury to the judicial system and to litigants caused by the failure to apply collateral estoppel in this case. As the brief of the *Amici Curiae* points out, inconsistent rulings impose grave hardships on litigants and needlessly consume decisionmaking resources.

3. The Solicitor's assertion that nonparty preclusion is permitted only where a party is "legally accountable for representing the non-party's interests" is not supported by most of the authority cited. *See* Respondents' Brief at 12. In *ITT Rayonier*, for example, the Ninth Circuit found the federal agency estopped by a judgment to which it was not a party even though no legally cognizable agency relationship existed between EPA and the State Department of Ecology (DOE). *See ITT Rayonier*, *supra*, 627 F.2d at 1003. The state agency was no more

legally accountable to EPA than Blue Cross was to the Secretary in this case. *See also Sea-Land Services, Inc. v. Gaudet*, 414 U.S. 573, 593 (1974)(no reference to legal accountability; nonparty estoppel against fiduciary representative held one of "several exceptions" to rule against nonparty estoppel); *Ethnic Employees of the Library of Congress v. Boorstin*, 751 F.2d 1405, 1411 n.8 (D.C. Cir. 1985) (not determining scope of nonparty estoppel because interests of present plaintiffs not sufficiently related to interests of the litigants in the prior law suit).

In any event, Petitioner has not argued for collateral estoppel on the basis of some accidental or abstract "coincidence of interests," Respondents' Brief at 12, between Blue Cross as private insurer and the Secretary. To the contrary, in this case Blue Cross and the Secretary have the identical concrete interest in the application of the same Medicare regulation to the same factual record. Moreover, as the *amici* point out, because the Secretary and fiscal intermediaries have created close ties between the Medicare program and private health insurance, the situation presented in this case will recur. Thus the Solicitor misses the crucial issue when he argues that collateral estoppel is unavailable because the state-court judgment was rendered against Blue Cross "in its capacity as a private insurer." The real issue is whether the policies articulated in *Montana*, when applied to the close relationship between the interests of Blue Cross as fiscal intermediary and Blue Cross as private insurer, justify collateral estoppel.[1]

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1. The Solicitor's suggestion that even a judgment against the Medicare fiscal intermediary would not be binding on the federal government in further litigation against Monsour Medical Center, *see* Respondents' Brief at 9-10, is directly contrary to this Court's holding in *United States v. Stauffer Chemical Co.*, 464 U.S. 165 (1984) (approving use of mutual defensive collateral estoppel against the federal government).

4. The Solicitor's brief suggests that administrative agencies must apply preclusion law only if required by a specific statute or regulation. Although the applicability of collateral estoppel and res judicata to administrative proceedings has not been definitively determined, the weight of authority indicates that preclusion is the rule rather than the exception. In *Kremer v. Chemical Constr. Corp.*, 456 U.S. 461, 469-470 (1982), this Court strongly suggested that the Equal Employment Opportunity Commission (EEOC) would be required to give preclusive effect to any state court judgment in the EEOC's determination of a complaint of discrimination. The Court reached this conclusion even though Congress explicitly provided by statute that state *administrative* determinations concerning discrimination are entitled only to "substantial weight" in EEOC proceedings. *See* 42 U.S.C. § 2000e-5(b). *See also University of Tennessee v. Elliott, supra*, 106 S. Ct. at 3225-3227. Significantly, *Kremer* assumed that preclusion would apply absent an express congressional intent to the contrary. *See also Graybill v. United States Postal Serv.*, 782 F.2d 1567, 1571 (Fed. Cir.), *cert. denied*, 107 S. Ct. 462 (1986); *Chisholm v. Defense Logistics Agency*, 656 F.2d 42, 46 (3d Cir. 1981).[2] When squarely faced with an agency's

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2. No such congressional intent can be found in the Medicare statute. The district court's assertion that "[s]erious questions remain concerning whether Medicare could have participated in the state court hearing without exhausting federal procedures under the Social Security Act," Pet. App. A-27, misreads the Medicare statute and its implementing regulations. The Secretary faces no exhaustion requirement. Both 42 U.S.C. §1395*oo* (1982 & Supp. III) and 42 C.F.R. §§405.1801 to 405.1890 (1986) require only that the "provider" initially challenge a reimbursement decision before the PRRB.

refusal to give preclusive effect to a prior judgment, the Second Circuit did not hesitate to reverse that decision. *See Safir v. Gibson*, 432 F.2d 137 (2d Cir.), *cert. denied*, 400 U.S. 942 (1970).[3]

5. The Solicitor also argues that the Third Circuit properly deferred to the Secretary's interpretation of the related-parties regulation as focusing on control at the time of the sale while simultaneously contending that this decision is consistent with prior cases holding that *all* circumstances before and after a transaction are relevant to relatedness. But the Third Circuit and the Secretary focused exclusively on facts at the time of the sale without acknowledging that this new interpretation of the related-parties regulation was inconsistent with the Provider Reimbursement Manual, with the Secretary's own decisions and with other circuits' rulings. *See* Petitioner's Brief at 18-21.

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3. Even if preclusion principles were not mandatory in agency decisionmaking, however, a federal court nonetheless would have to apply principles of collateral estoppel. *See, e.g.*, 28 U.S.C. §1738; *University of Tennessee v. Elliott, supra*, 106 S. Ct. at 3225-3227 (policies of federalism and repose generally require federal courts to apply preclusion principles); *Allen v. McCurry*, 449 U.S. 90, 99 (1980). The Administrative Procedure Act requires a court to set aside an administrative decision that is arbitrary, capricious or not in accordance with law. *See* 5 U.S.C. §706. The PRRB's decision directly contradicts the decision of the Pennsylvania courts. The Pennsylvania judgment is the controlling law for purpose of the Administrative Procedure Act, and consequently the PRRB's decision was not in accordance with law.

Respectfully submitted,

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